No. 00-1471

IN THE

Supreme Court of the United States

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., *et al.*,
Petitioners,

v.

JANIE MILLER, COMMISSIONER OF THE KENTUCKY DEPARTMENT OF INSURANCE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

JOINT APPENDIX

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Petition for a Writ of Certiorari filed March 22, 2001
Certiorari Granted June 28, 2002

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APPENDIX A

General Docket
US Court of Appeals for the Sixth Circuit

Court of Appeals Docket #: 98-6308 Filed: 10/1/98
Nsuit: 3950 Constitutional - State Statute
KY Assoc Health Plan, et al v. Nichols
Appeal from: Eastern District of Kentucky at Frankfort

* * * *

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC. Plaintiff - Appellant	Barbara Reid Hartung FTS 587-3695 502-589-4200 [COR ret] Greenebaum, Doll & McDonald 101 S. Fifth Street Suite 3300 National City Tower Louisville, KY 40202-3197 Robert N. Eccles FTS 383-5414 202-383-5363 [COR LD NTC ret] Karen M. Wahle FTS 383-5414 202-383-5366 [COR ret] O'Melveny & Myers 555 13th Street, N.W. Suite 500

	Washington, DC 20004-1109
ADVANTAGE CARE INC Plaintiff - Appellant	Barbara Reid Hartung (See above) [COR ret] Robert N. Eccles (See above) [COR LD NTC ret] Karen M. Wahle (See above) [COR ret]
AETNA HEALTH PLANS OF OHIO, INC. Plaintiff - Appellant	Barbara Reid Hartung (See above) [COR ret] Robert N. Eccles (See above) [COR LD NTC ret] Karen M. Wahle (See above) [COR ret]
CHOICECARE HEALTH PLANS, INC. Plaintiff - Appellant	Barbara Reid Hartung (See above) [COR ret] Robert N. Eccles (See above) [COR LD NTC ret] Karen M. Wahle (See above)

[COR ret]

FHP OF OHIO INC.
Plaintiff - Appellant

Barbara Reid Hartung
(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

HMPK INC
Plaintiff - Appellant

Barbara Reid Hartung
(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

HPLAN INC
Plaintiff - Appellant

Barbara Reid Hartung
(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

HUMANA HEALTH PLAN INC.

Barbara Reid Hartung

Plaintiff - Appellant

(See above)
[COR ret]

Robert N. Eccles
(See above)
[COR LD NTC ret]
Karen M. Wahle
(See above)
[COR ret]

v.

GEORGE NICHOLS, III, in his official capacity as Commissioner of the Kentucky Department of Insurance
Defendant - Appellee

Anna R. Gwinn
FTS 564-1456
502-564-6032
[COR ret]
Elizabeth A. Johnson
502-564-6032
[COR LD NTC ret]
Kentucky Department of Insurance

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC.; ADVANTAGE CARE INC; AETNA HEALTH PLANS OF OHIO, INC.; CHOICECARE HEALTH PLANS, INC.; FHP OF OHIO INC; HMPK INC; HPLAN INC; HUMANA HEALTH PLAN INC.
Plaintiffs - Appellants

v.

GEORGE NICHOLS, III, in his official capacity as Commissioner of the Kentucky Department of Insurance
Defendant - Appellee

10/1/98 Civil Case Docketed. Notice filed by Appellants Health Maintenance, Advantage Care Inc, Aetna Health Plans, Choicecare Health, FHP of Ohio Inc, HMPK Inc, HPLAN Inc, Humana Health Plan. Transcript needed: y (ac)

10/5/98 Joint MOTION filed to consolidate for briefing and submission cases 98-5941/6308 . Motion filed by Shaun T. Orme for Appellee George Nichols, Karen M. Wahle for Appellants Humana Health Plan, HPLAN Inc, HMPK Inc, FHP of Ohio Inc, Choicecare Health, Aetna Health Plans, Advantage Care Inc, Health Maintenance. [98-6308] (ac)

* * * *

10/22/98 ORDER filed denying motion to consolidate 98-5941 with 98-6308 for briefing filed by Shaun T. Orme, Karen M. Wahle. [98-6308] (ac)

* * * *

11/9/98 Copy of District Court Order filed staying proceedings pending resolution by 6th Circuit. (ac)

* * * *

9/20/99 CAUSE ARGUED on 9/20/99 by Robert N. Eccles for Appellant Humana Health Plan, Appellant HPLAN Inc, Appellant HMPK Inc, Appellant FHP of Ohio Inc, Appellant Choicecare Health, Appellant Aetna Health Plans, Appellant Advantage Care Inc, Appellant KY Assoc Health Plan, Shaun T. Orme for Appellee George Nichols before Judges Kennedy, Norris, Holschuh. [98-6308] (me)

9/7/00 OPINION filed: The judgment of the district court is AFFIRMED in part and the case is REMANDED in part in

accordance with the opinion of this court, decision for publication pursuant to local rule 206. [98-6308] Cornelia G. Kennedy, Alan E. Norris, Circuit Judges, John D. Holschuh, Authoring Judge. (Judge Holschuh delivered the opinion of the court, in which Judge Norris joined. Judge Kennedy delivered a separate dissenting opinion with respect to Part III of the majority opinion) (ac)

9/7/00 JUDGMENT: AFFIRMED in part and REMANDED in part. (ac)

9/21/00 PETITION for en banc rehearing filed by Karen M. Wahle for Appellants Humana Health Plan, HPLAN Inc, HMPK Inc, FHP of Ohio Inc, Choicecare Health, Aetna Health Plans, Advantage Care Inc, KY Assoc Health Plan. Certificate of service date 9/20/00. [98-6308] (blh)

10/11/00 LETTER SENT by blh to Shaun T. Orme for Appellee George Nichols notifying that party is directed to respond to a petition for en banc rehearing [2225106-1] filed by Karen M. Wahle. Response due by 10/25/00. [98-6308] (blh)

10/25/00 RESPONSE to a petition for en banc rehearing [2225106-1] filed by Karen M. Wahle. Response filed by Elizabeth A. Johnson for Appellee George Nichols. Certificate of service date 10/24/00. [98-6308] (blh)

11/20/00 ORDER filed denying petition for en banc rehearing [2225106-1] filed by Karen M. Wahle [98-6308]. Cornelia G. Kennedy, Alan E. Norris, Circuit Judges; John D. Holschuh, District Judge. (blh)

11/29/00 MANDATE ISSUED with no cost taxed [98-6308] (ac)

* * * *

3/27/01 U.S. Supreme Court notice filed regarding petition for writ of certiorari filed by Appellant KY Assoc Health Plan. Filed in the Supreme Court on 03-22-01 , Supreme Ct. case number: 00-1471 . [98-6308] (swh)

7/8/02 U.S. Supreme Court letter filed granting petition for writ of certiorari [2329643-1] filed by KY Assoc Health Plan [98-6308]. Filed in the Supreme Court on 06-28-02 . (swh)

APPENDIX B

U.S. District Court

Eastern District of Kentucky (Frankfort)

CIVIL DOCKET FOR CASE #: 97-CV-24

Health Mntnc Orgnztn, et al v. Nichols

Filed: 04/04/97
Assigned to: Judge Joseph M. Hood
Demand: $0,000
Nature of Suit: 950
Lead Docket: None
Jurisdiction: Federal Question
Dkt# in other court: None
Cause: 28:1331 Federal Question: Other Civil Rights

HEALTH MAINTENANCE ORGANIZATION ASSOCIATION OF KENTUCKY, INC. plaintiff	John Armstrong West FAX 859-655-4239 [COR LD NTC] Greenebaum, Doll & McDonald P.O. Box 2673 50 E. Rivercenter Boulevard Suite 1800 Covington, KY 1012-2673 859-655-4200 Barbara Reid Hartung FAX 502-587-3695 [COR LD NTC] Greenebaum, Doll

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ADVANTAGE CARE, INC.
plaintiff
[term 02/22/01]

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(See above)
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Barbara Reid Hartung
[term 02/22/01]
(See above)
[COR LD NTC]

Robert N. Eccles
[term 02/22/01]
(See above)
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[COR LD NTC]
O'Melveny & Meyers
555 13th Street N.W.
Washington, DC 20004
202-383-5300

AETNA HEALTH PLANS, of Ohio, Inc.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)

[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

CHOICECARE HEALTH PLANS, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

FHP OF OHIO, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]

Karen M. Wahle
(See above)
[COR LD NTC]

HMPK, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

HPLAN, INC.
plaintiff

John Armstrong West
(See above)
[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

HUMANA HEALTH PLAN, INC.
plaintiff

John Armstrong West
(See above)

[COR LD NTC]

Barbara Reid Hartung
(See above)
[COR LD NTC]

Robert N. Eccles
(See above)
[COR LD NTC]
Karen M. Wahle
(See above)
[COR LD NTC]

v.

GEORGE NICHOLS, III, in his Official capacity as Commissioner of the Kentucky Department of Insurance
defendant

Anna R. Gwinn
[COR LD NTC]
Shaun T. Orme
[term 12/12/00]
[COR LD NTC]
Julie M. McPeak
[COR LD NTC]
Elizabeth A. Johnson
[COR LD NTC]
Kentucky Department of Insurance
P.O. Box 517
215 W. Main Street
Frankfort, KY 40601
502-564-6032

DOCKET PROCEEDINGS

DATE # DOCKET ENTRY

4/4/97 1 COMPLAINT (2 summons(es) issued) with copy, Fee Paid $150.00, Receipt No. 065225 (cbd)

* * * *

4/15/97 4 RETURN OF SERVICE executed upon defendant George Nichols III on 4/7/97 by certified mail (cbd)

4/15/97 5 RETURN OF SERVICE executed upon A. B. Chandler III, Kentucky Attorney General on 4/7/97 by certified mail (cbd) [Edit date 06/04/97]

4/24/97 6 NOTICE OF INTENTION NOT TO INTERVENE by Attorney General KY (cbd)

4/25/97 7 ANSWER by defendant George Nichols III to [1-1] (cbd)

* * * *

8/19/97 24 MOTION by plaintiff Advantage Care, Inc., plaintiff Aetna Health Plans, plaintiff ChoiceCare Hlth Pln, plaintiff FHP of Ohio, Inc., plaintiff HMPK, Inc., plaintiff HPlan, Inc., plaintiff Humana Hlth Plan Inc, plaintiff KY Dept. of Ins., plaintiff Health Mntnc Orgnztn for partial summary judgment (cbd)

* * * *

9/16/97 31 MOTION by plaintiff Advantage Care, Inc. for preliminary injunction (cbd) [Entry date 09/17/97]

* * * *

9/19/97 34 RESPONSE by defendant George Nichols III to Motion for Preliminary Injunction [31-1] (cbd) [Entry date 09/22/97]

9/22/97 35 GENERAL MINUTES: before Joseph M. Hood Date(s) 9/22/97 Court Reporter K. Marshall IT IS ORDERED that all admin. enforcement actions now before the Commisioner and any other proceedings that may brought before the Comm. are STAYED pending Court's ruling on parties cross motions for summary judgment (cc: all counsel) (cbd)

10/15/97 36 MOTION by defendant George Nichols III for partial summary judgment (cbd)

* * * *

11/24/97 40 RESPONSE by plaintiff to motion for partial summary judgment [36-1] (cbd)

* * * *

12/15/97 42 REPLY by defendant George Nichols III to response to motion for partial summary judgment [36-1] (cbd)

12/15/97 -- SUBMITTED re motion for partial summary judgment [36-1] (cbd)

* * * *

8/6/98 43 MEMORANDUM OPINION AND ORDER: by Judge Joseph M. Hood; 1) pltfs' motion for partial summary judgment [24-1] is DENIED, 2) dft's mtn for partial sum jgm is GRANTED [36-1] (cc: counsel) (cbd)

* * * *

9/3/98 45 UNOPPOSED MOTION by plaintiff for partial final judgment under Rule 54(b), or, alternatively certification under 28 U.S.C. 1292(b) (cbd)

* * * *

9/3/98 -- SUBMITTED re motion for partial final judgment under Rule 54(b) [45-1], re motion certification under 28 U.S.C. 1292(b) [45-2] (cbd)

* * * *

9/18/98 48 ORDER by Judge Joseph M. Hood; IT IS ORDERED pltfs' motion for partial final judgment under Rule 54(b) [45-1] is GRANTED 2) ct's order dated 8/6/98 [Record No. 43] is FINAL and APPEALABLE and THERE IS NO JUST CAUSE FOR DELAY (cc: all counsel) (cbd) [Edit date 09/23/98]

9/22/98 49 MEMORANDUM OPINION: by Judge Joseph M. Hood; this ct believes that entry of a partial final jgm under Rule 54(b) as to Count I of the pltfs' cmp is warranted. A sep. order will this date issue (cc: all counsel) (cbd) [Entry date 09/23/98]

9/22/98 50 JUDGMENT: by Judge Joseph M. Hood; ORDERED, ADJUDGED, and DECREED that Count I of pltfs' Cmp is dismissed (cc: all counsel) (cbd) [Entry date 09/23/98]

9/25/98 51 NOTICE OF APPEAL by plaintiff Humana Hlth Plan Inc, plaintiff HPlan, Inc., plaintiff HMPK, Inc., plaintiff FHP of Ohio, Inc., plaintiff ChoiceCare Hlth Pln, plaintiff Aetna Health Plans, plaintiff Advantage Care, Inc., plaintiff Health Mntnc Orgnztn from Dist. Court decision entered 9/22/98 [50-1], [49-1], 9/18/98 [48-1], 8/11/98 [44-1] (cc: all counsel) (cbd)

* * * *

11/6/98 55 ORDER by Judge Joseph M. Hood; this action is stayed pending resolution of this issue by 6CCA (cc: all counsel) (cbd)

* * * *

12/1/00 58 MANDATE from 6CCA: ORD jgm of district ct is AFFIRMED in part & the case is REMANDED in part in accordance w/ the opinion of this ct [Appeal [51-1] (cbd) [Entry date 12/04/00]

* * *

2/22/01 63 GENERAL MINUTES: before Joseph M. Hood Date(s) 2/12/01 Court Reporter Ann Banta: ORD oral mtn of Advantage Care, Inc. for voluntary dismissal is GRANTED. Oral mtn by pltf for stay of action pending ruling on Writ of Certiorari is GRANTED. If Writ is denied, dft shall have 30 days from ruling to file his mtn for sum jgm & pltf shall have 15 days thereafter to respond (cc: all counsel) [EOD Date: 2/22/01] (cbd)

* * * *

7/10/02 -- REMARK: Pet for writ of cert granted 6/28/02. (sam)

END OF DOCKET: 3:97cv24

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APPENDIX C

Humana
Health Care Plans

HCT02AA4

KENTUCKY PHYSICIAN'S PLAN

Offered by Humana Health Plan, Inc.

Louisville, Kentucky 40201

Group Plan Sponsor:

HEALTHCARE RECOVERIES, INC.

Group Plan Number: 41308 Plan 006 Option 620

CERTIFICATE OF COVERAGE

We, Humana Health Plan, Inc., will directly provide or pay for the services described under the provisions of the Group Plan to you and your dependents, if any. If we provide the service directly, we arrange or contract with physicians, hospitals, and other providers of medical care and employ administrative personnel to directly provide, organize, and arrange for such service.

The physicians, hospitals, and providers of medical care are not our agents or employees, nor are we their agents or employees.

HUMANA HEALTH PLAN, INC.

President

HP 1/86

HCT03AX0

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DEFINITIONS

ELIGIBILITY AND EFFECTIVE DATES

TERMINATION PROVISION

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RIGHT OF REIMBURSEMENT

PROVISIONS APPLICABLE TO MEDICARE ELIGIBLES

PROVISIONS FOR REIMBURSEMENT OR PAYMENT OF SERVICES

GRIEVANCE PROCEDURE

HEALTH SERVICES AGREEMENT

CO-PAYMENT SCHEDULE

HDF01BX0

DEFINITIONS

Here are some terms used in your certificate. Other terms may be defined in the sections which follow.

ACCIDENT means a non-occupational injury which is:

1. caused by an event which is sudden and unforeseen; and
2. exact as to time and place of occurrence.

ACTIVE SERVICE means that you are performing all of your regular duties on a full-time basis for your employer on a regularly scheduled work day. You will be considered to be in active service on a non-scheduled work day only if you are in active service on the last regularly scheduled work day.

ADMISSION means entry into a facility as a registered inpatient according to the rules and regulations of that facility. An admission ends when the insured person is discharged, or released, from the facility and is no longer registered as an inpatient.

AFFILIATE means a company effectively controlled by the group or associated with the group under common ownership or control. The group must notify us and receive our approval as to which affiliates will be covered under the Group Plan.

AMBULANCE means a professionally operated vehicle equipped for the transportation of a sick or injured person to or from the nearest medical facility qualified to treat the person's sickness or injury. Use of the ambulance must be medically necessary and/or ordered by a physician and must be the most reasonable method of transportation.

AMBULATORY SURGICAL CENTER means an institution which meets all of the following requirements.

1. It must be operated by physicians and a medical staff which includes registered nurses.
2. It must have permanent facilities and equipment for the primary purpose of performing surgical procedures.
3. It must provide continuous physicians' services on an outpatient basis.
4. It must admit and discharge patients from the facility within the same work day.
5. It must be licensed in accordance with the laws of the jurisdiction where it is located. It must be run as an ambulatory surgical center as defined by those laws.
6. It must not be used for the primary purpose of terminating pregnancies, or as an office or clinic for the private practice of any physician or dentist.

HDF02AX0

CALENDAR YEAR means the period of time which begins on any January 1st and ends on the following December 31st. When a person first becomes covered under the Group Plan, the first calendar year begins for him or her on the effective date of his or her coverage and ends on the December 31st coinciding with or next following his or her effective date.

CERTIFICATE means this document, which describes the services provided and to whom and how services are provided or paid.

CHILD means your natural born child, legally adopted child or a stepchild. The term also includes any child for whom you are the legal guardian; a child who is dependent upon you for health care coverage pursuant to a valid court order; or any child who lives with you in a normal parent-child relationship if the child qualifies for the dependent exemption on your current income tax forms under the Internal Revenue Code and the Federal Tax Regulations. We have the right to request proof of the child's dependency status.

CO-PAYMENT AMOUNT OR CO-PAYMENT PERCENTAGE means that dollar amount or percentage of charges for covered services which must be paid to the provider of the services by or on behalf of the member receiving them.

DAY means a 24-hour period starting at 12:01 a.m. at the group's address.

HDF03BA0

DEPENDENT means:

1. your lawful spouse; and
2. an unmarried child from birth to age 19. The term also includes a child under the age of 25, if that child is enrolled in an educational institution as a full-time student and is actively attending class on a regular basis. Semester breaks do not jeopardize a child's dependent status. However, if a child is not enrolled and actively attending an institution as a full-time student for the semester following the break, that child will no longer be considered a dependent under the Group Plan and coverage will terminate.

DURABLE MEDICAL EQUIPMENT means equipment, recognized as such by Medicare Part B, that meets all of the following criteria.

1. It can stand repeated use.
2. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience.
3. It is usually not useful to a person in the absence of sickness or injury.
4. It is appropriate for home use.
5. It is related to the patient's physical disorder.
6. It is for temporary use only.
7. It is certified in writing by a physician as being medically necessary.

ELECTIVE PROCEDURE means a medical procedure which: is not considered to be an emergency; and may be delayed by the member to a later point in time.

EMPLOYEE means a person who is in active service for the group or an affiliate on a full-time basis. The employee must be paid by the group or affiliate for work done at the group's or affiliate's usual place of business or some other location which is usual for the employee's particular duties, other than the employee's home.

EXPERIMENTAL OR INVESTIGATIONAL means a drug, biological product, device, medical treatment or procedure that meets any one of the following criteria, as determined by us:

1. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is the subject of ongoing phase I, II, or III clinical trials, or
2. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure when applied to the circumstances of a particular patient is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or
3. **Reliable Evidence** shows the drug, biological product, device, medical treatment, or procedure is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.

RELIABLE EVIDENCE shall mean only published reports and articles in the authoritative medical and scientific literature; the PDQ database of the National Cancer Institute; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, biological product, device, medical treatment, or procedure; the written informed consent used by the treating facility or another facility studying substantially the same drug, biological product, device, medical treatment, or procedure; or regulations and other official actions and publications issued by the U.S. Food and Drug Administration or the Department of Health and Human Services.

FULL-TIME, for an employee, means a work week of at least 30 hours.

GROUP means the Group Plan Sponsor.

HDF04DX1

GROUP PLAN means the document describing the full plan of services we provide or pay for as contracted for by the group.

HOSPITAL means an institution which meets all of the following requirements.

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis.
2. It must provide or operate, either on its premises or in facilities available to the hospital on a pre-arranged basis, medical, diagnostic and surgical facilities.
3. Care and treatment must be given by and supervised by physicians. Nursing services must be provided on a 24 hour basis and must be given by or supervised by registered nurses.
4. It must be licensed by the laws of the jurisdiction where it is located. It must be run as a hospital as defined by those laws.
5. It must not be primarily a:

   a. convalescent, rest or nursing home; or
   b. a facility providing custodial care or educational services.

The term also includes licensed or accredited treatment facilities which are properly accredited to provide psychiatric, diagnostic and therapeutic services for the treatment of patients who have mental illnesses. In addition, if services specifically for the treatment of a physical disabil'- are provided in a licensed hospital, provision of those services will not be denied solely because such hospital is primarily of a rehabilitative nature and lacks surgical facilities. However, the hospital must be accredited by one of the following:

1. the Joint Commission on Accreditation of Healthcare Organizations;
2. the American Osteopathic Hospital Association; or
3. the Commission on the Accreditation of Rehabilitative Facilities.

HOSPITAL CONFINEMENT or **HOSPITAL CONFINED** means that a member is a registered inpatient in a hospital as the result of a physician's recommendation.

INJURY means non-occupational bodily loss or harm.

HDF05AX1

INTENSIVE CARE UNIT means a special unit of a hospital which:

1. treats patients with serious sicknesses or injuries;
2. can provide special life-saving methods and equipment;
3. admits patients without regard to prognosis; and
4. provides constant observation of patients by a specially trained nursing staff.

MEDICAID means a state program of medical care for needy persons, as established under Title 19 of the Social Security Act of 1965, as amended.

MEDICAL COMPLICATIONS OF PREGNANCY means conditions needing hospital confinement where the diagnosis is different from pregnancy, but the diagnosed condition may be caused or affected by it. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, puerperal infection and disease of the vascular system. Also included are serious medical and surgical conditions relating to pregnancy, such as hemopoietic nervous or endocrine systems, hyperemesis gravidarum, toxemia and eclampsia of pregnancy. It also includes non-elective caesarean section, miscarriage and ectopic pregnancy which is terminated or the spontaneous termination of a pregnancy which occurs during a period of gestation in which a viable birth is not possible.

This term does not include conditions such as false labor, occasional spotting, bed rest prescribed by a physician, morning sickness or any similar problems caused by a difficult pregnancy which cannot be classified as distinct from the pregnancy.

MEDICAL EMERGENCY means a physical condition for which services are required to provide an immediate diagnosis and treatment of a condition which occurs suddenly and unexpectedly and could become a threat to life or limb if medical services were not rendered immediately.

MEDICARE means a program of medical insurance for the aged and disabled, as established under Title 18 of the Social Security Act of 1965, as amended.

MEDICALLY NECESSARY SERVICES means services and supplies ordered by a physician and customarily recognized in the physician's profession as appropriate in the care and treatment of the patient's diagnosed sickness or injury.

In order to be considered medically necessary, the services or supplies must be:

1. consistent with the symptom or diagnosis and treatment of the member's injury or sickness;
2. appropriate with regard to standards of good medical practice;
3. not solely for the convenience of a member, physician, hospital or ambulatory care facility; and
4. the most appropriate supply or level of service which can be safely provided to the member. When applied to the care of an inpatient, it further means that the member's medical symptoms or conditions require that the services cannot be safely provided to the member on an outpatient basis.

MEMBER means you or any dependent while covered under the Group Plan.

NON-PARTICIPATING HOSPITAL means a hospital which has not been designated as a participating hospital by us to provide services to members.

NON-PARTICIPATING PHYSICIAN means a physician who has not been designated as a participating physician by us to provide services to members.

NON-PARTICIPATING PROVIDER means a non-participating hospital, a non-participating physician or another provider who has not been designated as a participating provider by us to provide services to members.

NURSE means a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

ORAL SURGERY means procedures to correct diseases, injuries and defects of the jaw and mouth structures. These procedures include but are not limited to the following:

1. Surgical removal of full bony impactions.
2. Mandibular (staple) implant.
3. Maxillary or mandibular frenectomy.
4. Alveolectomy and alveoplasty.
5. Orthognathic surgery.
6. Periodontal surgery, including gingivectomies.

OUTPATIENT means that a member is not hospital confined.

OUTPATIENT SURGERY means surgery that is performed in a physician's office, ambulatory surgical center, free-standing medical clinic or the outpatient department of a hospital.

OPEN ENROLLMENT PERIOD means that period of time in each Group Plan year when, by agreement between the group and us, eligible persons can enroll in the Group Plan or terminate their coverage.

PARTICIPATING HOSPITAL means a hospital which has signed an agreement with us or has been designated by us to provide services to members.

PARTICIPATING PHYSICIAN means a physician who has signed an agreement with us or has been designated by us to provide services to member.

PARTICIPATING PROVIDER means a participating hospital, a participating physician or another provider who has signed an agreement with us or has been designated by us to provide services to members. A complete list of participating providers will be given to you.

PERIOD OF CONFINEMENT means one period of confinement, except successive periods of confinement are considered one period unless the second period of confinement is due to injury or sickness entirely unrelated to the prior period of confinement. If the second period of confinement is due to an injury or sickness related to the condition which caused the first confinement, the confinements will be considered separate if the member is free of hospital confinement for at least 7 consecutive days.

PERIODONTICS means the branch of dentistry concerned with the study, prevention and treatment of diseases of the tissues and bones supporting the teeth.

PHYSICIAN means a licensed medical practitioner who is practicing within the scope of his or her license and whose services are required to be covered under the Group Plan by the laws of the jurisdiction where the treatment is given.

PSYCHIATRIC DISORDER means neurosis, psychoneurosis, psychopathy or psychosis.

PSYCHIATRIC TREATMENT PROGRAM means those services offered by licensed mental and nervous programs, licensed drug abuse rehabilitation programs, and alcoholism rehabilitation programs. These programs must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations or in compliance with equivalent standards or be approved by the state where the program is run.

REASONABLE CHARGES mean charges that do not exceed negotiated schedules of payments developed by us which are accepted by Participating Providers within a geographic area specified by us as payment in full. Services rendered inside this specified geographic area by Non-Participating Providers will be reimbursed according to these Participating Provider schedules, unless otherwise agreed to by the Group and us. In the event that an insured receives services outside this specified geographic area, services will be covered according to reimbursement schedules developed by independent organizations and fee schedule companies for the area in which the services are rendered.

ROOM AND BOARD means all services provided by a hospital, including room and meals and all general services and activities needed for the care of registered bed patients.

ROUTINE NURSERY CARE means the charges made by a hospital for the use of the nursery. It includes normal services and supplies given to well newborn children following birth. Physician visits are not considered routine nursery care. Treatment of an injury, sickness, birth abnormality, congenital defect following birth and care resulting from prematurity is not considered routine nursery care.

SERVICE OR SERVICES means any services or supplies we cover under the Group Plan.

SICKNESS means any non-occupational disease or illness. The term also includes: (a) pregnancy; (b) any medical complications of pregnancy; and (c) a covered newborn's congenital defects or birth abnormalities, including premature birth for which more than routine nursery care is required.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SUBSCRIBER means you, while you are covered under the Group Plan.

SURGICAL PROCEDURE means any of the following procedures (excluding oral surgical procedures):

1. incision, excision or electrocauterization of any organ or body part;
2. reconstruction of any organ or body part or the suture repair of lacerations;
3. reduction of a fracture or dislocation by manipulation;
4. use of endoscopic procedure to explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter;
5. puncture for aspiration;
6. injection for contract media testing; or
7. laser surgery.

TOTAL DISABILITY or **TOTALLY DISABLED** means your continuing inability, as the result of injury or sickness, to perform the material and substantial duties of any occupation for which you are suited by reason of education, training or experience. The term also means a dependent's inability to engage in the normal activities of a person of like age. If a dependent is employed, the term means the dependent's inability to perform his or her job.

WEEKEND NON-EMERGENCY HOSPITAL ADMISSION means an admission to a hospital on a Friday or a Saturday at the convenience of the member or his or her physician when there is no cause for an emergency admission and the member receives no surgery or therapeutic treatment until the following Monday or later.

YOU, YOUR OR YOURS means the person who is eligible for coverage under the Group Plan as a subscriber. It does not mean any person who is covered as a dependent under the Group Plan.

WE, US or OUR means the Humana Health Plan, Inc.

HPHCR032

ELIGIBILITY AND EFFECTIVE DATES

EFFECTIVE DATE FOR SUBSCRIBERS

A person who is eligible for coverage may elect to be covered by the Group Plan only by signing an enrollment form approved and accepted by us. The effective date of coverage depends upon the date on which the person enrolls.

Subject to the PROVISO and your making any required subscription fee contributions, your coverage will start as described in the paragraphs which follow.

1. If you are eligible for coverage on the effective date of the Group Plan, your coverage will start:

   a. on the effective date of the Group Plan if you enrolled for coverage on or before that date.
   b. on the date you enroll if you enroll later than, but within 31 days after, the effective date of the Group Plan.

   If you become eligible after the effective date of the Group Plan, and you enroll on or before the date you become eligible, your coverage will start the date you become eligible.

2. If you become eligible after the effective date of the Group Plan and you enroll within 31 days after the date you become eligible, your coverage will start on the date you enroll.

3. If you must make subscription fee contributions for your coverage and you enroll more than 31 days after the date you became eligible or you apply to reinstate coverage that has lapsed, you must give us evidence of your health status at no cost to us. If we approve this evidence, your coverage will start on the day we specify.

PROVISO. If you are not actively at work on the date your coverage would become effective, it will not become effective until you return to active service. If you are not actively at work when your coverage is being changed, increased, or services are being added while you are covered under the Group Plan, the change, increase, or new services will not become effective for you until you return to active service. This proviso will not apply to retirees, if any, covered under the Group Plan.

HPHCR034

ELIGIBILITY FOR YOUR DEPENDENTS

You become eligible for coverage for your dependents on the latest of the following dates:

1. the date you become eligible for coverage; or
2. the date you acquire your first dependent; or
3. the date on which provisions covering dependents are made a part of the Group Plan.

If a dependent is eligible for coverage as a subscriber, you may not enroll him or her as both a subscriber and a dependent. In addition, no one may be considered as a dependent of more than one subscriber.

EFFECTIVE DATE FOR YOUR DEPENDENTS

You may elect to cover your dependents by the Group Plan only by signing an enrollment form approved and accepted by us. The effective date of coverage for each dependent depends on the date on which you enroll for coverage for that dependent.

Subject to the PROVISO, the coverage for your dependents will start as shown below; however, it will not start before you become a subscriber and make any required subscription fee contributions.

1. The coverage for each dependent becomes effective on the date you enroll for it, if you enroll for coverage for your dependent(s) on or before the date you: (a) become eligible for dependent coverage; or (b) first acquire the dependent.

2. If you enroll for coverage for your dependent(s) within 31 days after you either become eligible for dependent coverage or first acquire the dependent, the coverage for each dependent becomes effective on the later of: (a) the date you become eligible; or (b) the date of enrollment.

3. If you must make subscription fee contributions for dependent coverage, the coverage for each dependent becomes effective on the date we accept the dependent's evidence of health status and agree in writing to cover the dependent if you enroll for dependents coverage more than 31 days after: (a) you become eligible for dependent coverage; or (b) you first acquire the dependent. If evidence must be given, it must be provided at your expense.

PROVISO. If a dependent, other than a newborn, is hospital confined on the date his or her Health Services coverage would become effective, it will not become effective until the day after he or she is discharged from the hospital. This also applies to change, increase or addition of Health Services while the dependent is covered under the Group Plan.

NEWBORN CHILDREN

If you have or acquire a newborn child as a dependent, the child is automatically covered under the Health Services Agreement from the moment of birth if you enroll the newborn for dependent coverage no later than 31 days after the date of the child's birth and make any required subscription fee contributions.

SPECIAL ENROLLMENT

If you or one of your eligible dependent(s) waived coverage under this Group Plan during the initial eligibility period and enrolled under your spouse's health plan, you or your dependent(s) may enroll under this Group Plan without medical underwriting if one of the following events occurs:

1. Your spouse's employer terminates coverage;or
2. Your spouse terminates employment; or
3. Your spouse has a change in hours or a change in position (for example switching from full-time to part-time); or
4. Your spouse dies.

When coverage is elected under this provision, enrollment must be completed within 31 days following the date coverage terminates under your spouse's plan; and, you may enroll only those eligible persons who were covered under your spouse's plan.

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE

If the Group Plan replaces the group's prior plan of group medical coverage and you are totally disabled or have a pre-existing condition, you may have limited coverage under the Group Plan. To be eligible for this limited coverage:

1. you must have been covered by the prior plan of group medical coverage on the day before the Group Plan becomes effective for the group; and
2. you must be in an eligible class under the Group Plan on the date it becomes effective for the group.

Limited coverage will be provided as follows:

TOTAL DISABILITY - We will provide limited coverage for totally disabled persons covered under the prior plan's extension of benefits as follows:

1. the Group Plan will provide benefits only for those covered medical services not directly related to the totally disabling condition; and
2. the Group Policy will not cover medical services directly related to the totally disabling condition. These services may be covered under the prior plan's extension of benefits provision, if any.

Our limited coverage of the totally disabled person will continue until the earliest of the following dates:

1. the date the person's total disability ends. If the total disability ends before the prior plan's extension of benefits is exhausted, the person will be eligible for the full coverage of the Group Plan, provided the person:
   a. returns to active service, if he or she is a subscriber; or
   b. is not hospital confined, if he or she is a dependent.

   No waiting period or pre-existing condition limitation will apply.
2. the date the person's coverage under the Group Plan terminates in accordance with the termination provisions of the Group Plan; or

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE (CONTINUED)

3. the date the prior plan's extension of benefits for the disabling condition is exhausted. If the person is still totally disabled at that time, the coverage of the Group Plan terminates. If the totally disabled person had dependent coverage under the Group Plan, coverage for his or her dependents also terminates.

If your coverage under the Group Plan terminates because the prior plan's extension of benefits is exhausted, you may convert your coverage, and that of your eligible dependents, in accordance with the conversion privilege of the Group Plan. The conversion privilege does not apply to a totally disabled dependent who exhausts the prior plan's extension of benefits.

When a former subscriber, whose coverage under the Group Plan was terminated because the prior plan's extension of benefits was exhausted, is no longer totally disabled, he or she must satisfy a new waiting period in order to become eligible for coverage again. In addition, the pre-existing condition limitation of the Group Plan will be applied.

When a former dependent, whose coverage under the Group Plan was terminated because the prior plan's extension of benefits was exhausted, is no longer totally disabled, he or she may become eligible for coverage again only if you have dependent coverage at that time. The pre-existing condition limitation will be applied.

PRE-EXISTING CONDITIONS - We will compare the pre-existing condition limitations of the Group Plan and the prior plan. The shortest limitation will become the adjusted limitation period and will be used to determine when coverage will be provided under the Group Plan, as follows.

1. If you satisfied the adjusted limitation period while covered under the prior plan, full coverage for the pre-existing condition will be provided under the Group Plan.

2. If you have not satisfied the adjusted limitation period, we will credit the period of time you were covered under the prior plan. You must then satisfy the remainder of the adjusted limitation period while covered under the Group Plan. Once the adjusted limitation period is fully satisfied, full coverage for the pre-existing condition will be provided under the Group Plan.

SPECIAL PROVISIONS FOR THE REPLACEMENT OF COVERAGE (continued)

WAITING PERIOD CREDITS - If you had not satisfied the waiting period of the prior plan on the day that plan ended, any periods of time that were satisfied will be applied to the appropriate waiting period of the Group Plan, if any.

DEDUCTIBLE CREDIT - If you become covered by the Group Plan, we will reduce the co-payment amounts of the Group Plan for the first calendar year by the amount of same or similar covered medical services received under the prior plan which were applied to that plan's current deductible before the prior plan ended. This credit will not apply if the Group Plan is replacing a health maintenance organization plan.

CO-PAYMENT LIMITS - Any amounts applied to the prior plan's co-payment limit or stop-loss limit WILL NOT be credited toward the satisfaction of any co-payment limits of the Group Plan.

HIT01AA0

TERMINATION PROVISIONS

TERMINATION OF YOUR COVERAGE

Your coverage will terminate on the earliest of the following dates:

1. the date you cease to be in a class of eligible persons or cease to qualify as a subscriber;
2. the last day for which you make any required subscription fee contribution for your coverage;
3. the last day for which the group makes any required subscription fee contribution for coverage on your behalf;
4. the date the Group Plan is terminated;
5. the date your Lifetime Maximum Covered Services Amount is reached; or
6. 31 days from the date you receive written notice that your coverage is being terminated for cause, as set forth on the next page.

TERMINATION OF YOUR DEPENDENT COVERAGE

A dependent's coverage will terminate on the earliest of the following dates:

1. the date your coverage terminates;
2. the date you cease to be in a class of persons eligible for dependent coverage;
3. the last day for which you make any required subscription fee contribution for dependent coverage;
4. the last day for which the group makes any required subscription fee contribution for dependents coverage on your behalf;
5. the date dependent coverage or the Group Plan is terminated;
6. the date a dependent reaches his or her Lifetime Maximum Covered Services Amount;
7. the date a dependent no longer qualifies as a dependent; or
8. 31 days from the date the dependent receives written notice that his or her coverage is being terminated for cause, as set forth on the next page.

HIT02AE0

TERMINATION FOR CAUSE

We will terminate a member's coverage for cause under the following circumstances:

1. If, after reasonable efforts, a satisfactory physician-patient or provider-patient relationship cannot be established or maintained with a member.
2. If a member fails to pay or arrange to pay his or her co-payments.
3. If a member allows an unauthorized person to use his or her identification card or uses the identification card of another subscriber. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying us the usual, customary and reasonable charges for those services.
4. If a member is disruptive for reasons unrelated to his or her use of medical services and the behavior prevents treatment to the member or other members of the Plan.
5. If a member or group perpetrates fraud and/or misrepresentation on claims or identification cards in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication and/or alteration of a claim or identification card.

A member who is being terminated for cause has 10 days from the date his or her coverage would otherwise terminate to initiate the Grievance Procedure. The member's coverage will continue until the Grievance Procedure is complete.

HANDICAPPED CHILDREN

If a dependent child who has reached the maximum age shown in the definition of dependent meets all of the requirements shown below, we extend dependents coverage under the Health Services Agreement for that child for as long as you remain covered for dependent coverage.

1. The child must be incapable of self-sustaining employment because of mental or physical handicap.
2. The child must rely on you for financial support.

You must give us proof of the child's handicap within 31 days of the date his or her Health Services coverage would otherwise end. We may request further proof of the child's continued incapacity from time to time during the 2-year period after the date the handicapped child reached the maximum age. After this 2-year period, we may only request further proof of the child's incapacity annually.

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HIT03DX0

RETIREMENT

If your active service ends because you retire, coverage will be continued until the date the group stops paying subscription fees for your coverage or otherwise terminates your coverage.

Any continuation of coverage must not be done on a selective basis.

HIT04CB0

WHEN COVERAGE TERMINATES UNDER THE HEALTH SERVICES AGREEMENT

If a member's coverage under the Health Services Agreement terminates:

1. it may be extended under the Extension of Coverage Under the Health Services Agreement provision, if the member is totally disabled when the Group Plan terminates;
2. it may be converted to a plan of medical coverage as described in the Health Services Agreement Conversion provision; or
3. it may be continued under the Optional Continuation of Health Services Coverage provision, if your health services coverage ends and is not replaced within 31 days.

A complete description of these provisions and when a member qualifies under these provisions follows.

EXTENSION OF COVERAGE UNDER THE HEALTH SERVICES AGREEMENT

We continue to provide or pay limited covered Health Services if the Group Plan terminates while a member is continuously totally disabled due to an illness or injury that commenced while this contract is in effect. The member must provide written notice to us within 31 days from the date the Group Plan terminates of his or her intention to receive extended benefits. Services are provided or paid only for the same injury or sickness which caused the member to be continuously totally disabled. Services for the disabling condition are provided or paid without subscription fee payment only while the member remains continuously totally disabled, until the earliest of:

1. the date the member is no longer continuously totally disabled; or
2. the date the member becomes covered by any medical coverage plan carried or sponsored by the employer;
3. the date the member's Lifetime Maximum Covered Services Amount, if any, is reached; or
4. the last day of the 3-month period following the date the Group Plan terminated.

No Health Services are extended to a child born as a result of a member's pregnancy which existed when the Group Plan terminated.

This provision does not apply to covered retired members.

HIT06ABO

HEALTH SERVICES AGREEMENT CONVERSION

WHO MAY CONVERT

If a member has been covered under the Health Services Agreement of the Group Plan and any prior plan replaced by the Group Plan for at least a total of 3 full calendar months, he or she may obtain a plan of medical benefits (called the conversion plan). A conversion plan may be obtained by:

1. you, if your Health Services coverage under the Group Plan terminates. You may also include in the conversion plan any dependents who were covered by the Group Plan on the date your coverage ends.
2. your covered spouse whose Health Services coverage under the Group Plan ends because of termination of the marriage or because of your death.
3. your covered child whose Health Services coverage under the Group Plan ends because he or she no longer qualifies as a dependent or because of your death.
4. your covered dependents when your Health Services coverage under the Group Plan ends and you cannot convert because you are eligible for Medicare.

No conversion plan is available if:

1. the member is eligible for Medicare;
2. issuance of the conversion plan would result in the member being overinsured.

HIT07BAO

A person will be considered to be overinsured if: his or her coverage under the Group Plan is replaced by similar group coverage within 31 days of the date coverage ends; or the benefits of the conversion plan, when combined with similar benefits, result in an excess of coverage. Similar benefits include:

1. those for which the person is covered by a hospital, medical, or surgical or medical expense insurance policy, by a hospital or medical service subscriber contract, or by a medical practice or other prepayment plan;
2. those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or
3. those available for the person by or through any state, provincial or federal law, other than Medicaid.

HOW TO CONVERT

We will give all of the necessary information about conversion to a member who is entitled to convert so that application may be made. Evidence of health status will not be required to obtain a conversion plan. A member entitled to convert must apply in writing and pay the first subscription fees on the conversion plan within 31 days after he or she is given proper notice of the right to conversion. Proper notice is written notice that is mailed or delivered to the member's last address as given by you to the Group Plan. In the event a member has this conversion right but does not receive proper notice of it, he or she can still apply. To do so the member must apply in writing and pay the first subscription fees on the conversion plan within 91 days after his or her eligibility for coverage under the Health Services Agreement ends. A member who does not so apply will not be entitled to a conversion plan.

THE CONVERSION PLAN

The conversion plan will be one we offer or arrange to offer at the time the first subscription fees are received.

The conversion plan is issued to you if you are entitled to convert. It will cover you and those dependents for whom you must convert. If you are not entitled to convert and your covered dependents are, the conversion plan is issued to the spouse and will cover all such dependents. If the conversion plan is for an individual dependent, it will be issued to that dependent.

The conversion plan takes effect on the day after the person's Health Services coverage under the Group Plan ends. The subscription fees of the conversion plan on its effective date are based on: (1) the class of risk to which the person entitled to convert belongs: (2) that person's age; and (3) the benefits chosen.

The conversion plan may not exclude any pre-existing condition not excluded by the Group Plan. During the first 12 months that the conversion plan is in effect, the amount payable by it may be reduced. The reduction would be equal to the services provided or paid by the Extension of Coverage Under the Health Services Agreement provisions of the Group Plan so that the total amount payable by the conversion plan and the services provided or paid by the Group Plan do not exceed the services that would be provided or paid by the Group Plan if the person's coverage had not ceased. After 12 months, the amount payable by the conversion plan will be reduced by any services still provided or payable by the Extension of Coverage Under the Health Services Agreement provisions of the Group Plan.

OPTIONAL CONTINUATION OF HEALTH SERVICES COVERAGE

If you are no longer eligible for coverage under the Health Services Agreement of the Group Plan, you may choose to continue these services for up to 9 months after the date your Health Services coverage terminates. You must give us written notice of your choice to continue coverage within 31 days after you are given proper notice of your right to continuation.

Proper notice is written notice that is mailed or delivered to your last address as given by you to the Group Plan.

In the event you have this right of continuation but you do not receive proper notice of it, you can still make the election. To do so you must make proper payment of subscription fees within 91 days after your eligibility for coverage under the Health Services Agreement ends.

You are responsible for sending us the subscription fee payments if you choose to continue coverage. If you fail to make proper payment of subscription fees to us, we are relieved of all liability for any coverage that was continued.

The option to continue coverage is not available if: (1) the Group Plan terminates or coverage for your entire class terminates and is not replaced by another group policy within 31 days after your coverage terminates; (2) you are eligible for similar group benefits, either on an insured or uninsured basis; (3) you were not covered by the Group Plan and the prior plan replaced by the Group Plan for at least 3 months prior to the date your coverage terminates; (4) you are eligible for Medicare; or (5) you are eligible for continuation under the Optional Continuation of Health coverage provision.

If you were covered under the Health Services Agreement for dependents coverage when your Health Services coverage terminated, you may choose to continue coverage for any dependent who was covered by the Group Plan. You cannot add dependents to your coverage during a period of continuation. The same terms with regard to the availability of continued coverage described above will apply to dependents.

Continued coverage terminates on the earliest of the following dates: (1) the last day of the 9 month period following the date you were no longer eligible for coverage; (2) the date you became covered for similar group benefits, either on an insured or uninsured basis; (3) the date you fail to make any required subscription fee contribution; (4) the date you reach your Lifetime Maximum Covered Services Amount; or (5) the date the Group Plan terminates and is not replaced by similar group benefits within 31 days.

Continued coverage for dependents terminates on the earlier of: the date your continued coverage terminates; or the date the dependent no longer qualifies as a dependent.

If continued coverage terminates and is not replaced by similar group coverage, you or your dependents may choose to convert to a conversion plan. To convert, you or your dependent must satisfy the terms of the Group Plan which apply to health services conversion.

CONTINUATION OF COVERAGE FOR DEPENDENTS

If your dependents are no longer eligible for coverage under the Health Services Agreement of the Group Plan because of your death or dissolution of marriage, or, with respect to a dependent child alone, ineligibility which results because he or she reaches the limiting age of the Group Plan, the ineligible dependent(s) may choose to continue coverage for up to 9 months after the date coverage terminates. This continuation is subject to the same terms, conditions and termination provisions as described for you under the Optional Continuation of Health Services Coverage above.

HIT1GAA0

OPTIONAL CONTINUATION OF HEALTH COVERAGE

The following provisions apply only to employer groups who elect to comply with provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If a covered person is no longer eligible for the coverage provided by the Group Plan because of one of the qualifying events described below, that person may choose to continue that coverage. He or she will be responsible for payment of the appropriate subscription fees for continued coverage, including any portion that the employer may have paid on his or her behalf.

The group will be responsible for sending us the subscription fee payments for those individuals who choose to continue their coverage. If the group fails to make proper payment of subscription fees to us, we are relieved of all liability for any coverage that was continued and the liability will rest with the group.

There are two categories of persons eligible for continued coverage. Persons eligible to continue are called "beneficiaries." Notification requirements and the period of time for which coverage may be continued differs for each category.

CATEGORY 1 BENEFICIARIES are:

1. Surviving spouses of covered employees and their dependent children;
2. Divorced or legally separated spouses and their dependent children;
3. Spouses of Medicare-eligible employees and their dependent children; and
4. Dependent children who become ineligible under the terms of the Group Plan.

Coverage for any of these individuals may be continued for up to 36 months following the date of the qualifying event.

Surviving spouses and spouses of Medicare-eligible employees who wish to continue coverage must notify the employer within 30 days of the qualifying event resulting in loss of coverage. Divorced or legally separated spouses and dependent children who become ineligible for coverage must notify the employer within 60 days of the later of (a) the date of the qualifying event or (b) the date the qualified beneficiary would lose coverage on account of the qualifying event. Within 14 days of receipt of the notice of a qualifying event, the employer will provide a form on which to indicate election of continued coverage. The form must be returned to the employer within 60 days of receipt. Coverage will continue during this 60-day period if the appropriate subscription fee is paid within 45 days of the date of election of continued coverage.

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OPTIONAL CONTINUATION OF HEALTH COVERAGE (CONTINUED)

CATEGORY 2 BENEFICIARIES are

1. Employees whose employment is terminated for reasons other than gross misconduct; and
2. Employees whose working hours have been reduced so that they are no longer eligible for coverage under the Group Plan.

Coverage for these individuals may be continued for up to 18 months following the date of termination or reduction of hours.

Your employer will give you a form to elect continuation of coverage for you and your covered dependents, if any, at the time of your termination or reduction in hours, or within 30 days of the event. The form must be returned to your employer within 60 days of receipt. Coverage will continue during this 60-day period if you pay the appropriate subscription fees within 45 days of the date you elect to continue the coverage.

If an employee is terminated for gross misconduct, he or she may continue coverage under the continuation coverage required by state law, if any.

TERMINATION OF CONTINUED COVERAGE

Continued coverage will terminate immediately for individuals in either category at the earliest of the following dates:

1. the date the employer ceases to provide any group health plan to employees;
2. the date the beneficiary fails to make timely subscription fee payments;
3. the date the beneficiary becomes covered under this or any other group health plan or becomes entitled to benefits under Medicare; or
4. the date a spouse remarries and becomes covered by another group health plan.

If continued health coverage terminates and is not replaced by similar group coverage, you and your dependents may choose to convert to a conversion plan. To convert, the terms of the Group Plan which apply to health services conversion must be satisfied.

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COORDINATION OF BENEFITS PROVISIONS APPLICABLE TO ALL SERVICES

DEFINITIONS

Here are some terms used in this provision.

ALLOWABLE EXPENSE means any necessary and reasonable item of expense at least a part of which is covered by any one of the plans that covers the person for whom claim is made. When the benefits from a plan are in the form of services rather than cash payments as may be the case with this plan, the reasonable cash value of each service is both an allowable expense and, for purposes of this provision, a benefit provided or payable.

COVERAGE DETERMINATION PERIOD means a calendar year or that part of a calendar year in which the person has been covered by this plan.

As used in this Coordination of Benefits provision only, **PLAN** means the coverage of medical or dental expenses or services by:

1. any group insurance plan, on an insured or uninsured basis;
2. group service plan contracts, group or individual practice or other pre-payment plans; or
3. labor-management trusteed plans, union welfare plans, employers organization plans or employee benefit organization plans.

The term does not include coverage under individual or franchise policies or contracts. Each plan or part of a plan which has the right to coordinate benefits is considered to be a separate plan.

WHAT A COORDINATION OF BENEFITS PROVISION DOES

If a person is covered by this plan and by any of the other plans described above, a coordination of benefits provision will be used when the amount of benefits provided or payable by this plan and the amount of benefits payable by any of the other plans for the same services would exceed the total amount of allowable expenses in a claim determination period.

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All benefits provided or payable under this plan are subject to coordination. A coordination of benefits provision determines:

1. the order in which all plans provide or pay their benefits; and
2. when, depending on the order of benefit determination, a plan may reduce or recover its benefit so that not more than 100% of the total amount of allowable expenses is provided or paid jointly by all plans.

ORDER OF BENEFIT DETERMINATION

In order to administer this provision, it is first necessary to determine the order in which all of the plans provide coverage. This order is shown below.

1. A plan which does not contain a coordination of benefits provision is considered to provide coverage before a plan which does contain a coordination of benefits provision.

2. A plan which covers a person on a basis other than coverage for dependents is considered to provide coverage before a plan which covers a person as a dependent.

3. A plan which covers a person as the dependent of a person whose birthday anniversary occurs earlier in the calendar year is considered to provide coverage before a plan which covers the person as the dependent of a person whose birthday anniversary occurs later in the calendar year. If either one of the plans does not have this "birthday rule" provision, then the plan without this provision is considered to determine its benefits before the plan which does contain this provision. In the case of divorced or legally separated parents, the order of benefit determination is as shown below.

   a. If there is a court decree which establishes financial responsibility for a dependent child's health care expenses, the plan of the parent with that responsibility is considered to provide coverage before the plan of the parent without the responsibility.

b. If there is no such decree and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody is considered to provide coverage before the plan of the parent without custody.

c. If the parent with custody of the child has remarried:

   1) the plan which covers the child as a dependent of the parent with custody provides coverage first;

   2) the plan which covers the child as a dependent of the step-parent provides coverage second; and

   3) the plan which covers the child as a dependent of the parent without custody provides coverage third.

If the above rules fail to establish the order of benefit determination, the plan which has covered the person for the longest time is considered to provide coverage first. However, a person may be covered as an active employee by one plan and as a retired or laid-off person by another plan. In this case, if both plans contain a provision regarding retired or laid- off employees, the plan which covers the person as an active employee is considered to provide coverage before the plan which covers the person as a retired or laid-off employee.

HOW BENEFITS ARE COORDINATED

If, based on the order of benefit determination, the benefits of this plan are provided or paid first, the coverage provided or paid by the other plans is ignored when we provide or pay services. If our plan's coverage should be provided or paid after that of any other plan, we add up the coverage provided or paid by each of the plans in the order in which it should be provided or paid and compare the total benefits to the total amount of allowable expenses. If the services we have provided or paid plus the coverage provided or paid under the other plans results in coverage which exceeds total allowable expenses, we have the right to reduce our benefit payment or recover the reasonable value of the services to the extent of the excess over total allowable expenses from: any person to whom such coverage was provided or benefits were paid, any insurance company, health care plan or other organization. This right of recovery shall be exercisable at our sole discretion.

The member shall, upon our request, execute such instruments or papers as may be required to secure our rights. When coordination of benefits reduced the total amount otherwise covered in a coverage determination period for a person covered by our plan, each service that would have been covered in the absence of coordination is reduced in proportion. The reduced amounts are charged against any applicable benefit limits of our plan. In no event will our provision of services be more than it would have been in the absence of other plans.

We reserve the right to release to or obtain from any insurance company or other organization or person any information which, in our opinion, we need for the purpose of coordination of benefits.

When services should have been provided or paid by our plan based on the terms of this provision and payments have been made by any other plan, we have the right to pay to any organization making these payments an amount we consider to be warranted. Amounts paid in this manner are considered to be services provided or paid by our plan. After we make such payments, we have no further liability.

When we have made an overpayment, we have the right to recover that payment to the extent of the excess. We may recover the overpayment from the person to whom it was made or from any insurance company or organization as described in these Coordination of Benefits provisions.

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PROVISIONS FOR SUBROGATION AND RIGHT OF REIMBURSEMENT

RIGHTS OF RECOVERY

Our intention is to preserve and assert our rights to recover for sums paid or benefits provided where circumstances warrant the assertion of our rights, to the fullest extent allowed by the applicable laws of the jurisdiction involved. Each provision below shall be considered severable, and if any provision is determined to be unenforceable or void, the remaining provisions shall remain unaffected.

SUBROGATION

This provision applies when another party (person or organization) is, or may be, considered responsible for causing injury or for payment of benefits due to a member's injury or sickness for which benefits under the Group Plan have been provided or paid. To the extent of such benefits, we are subrogated to all rights and claims for recovery the member has against any party (including a health care carrier) responsible for the injury for payment to the member on account of the injury.

RIGHT OF REIMBURSEMENT

If payment (by settlement, judgment or any other manner) is made, or may be made, in the future by, or on behalf of, a responsible party to the member, expenses arising from the member's injury or sickness are not covered by us.

However, if we receive a claim for which benefits would be payable in the absence of a responsible party as described above, we will pay those benefits subject to the following conditions:

1. We will automatically have a lien to the extent of benefits advanced upon any recovery, by settlement, judgement or otherwise that you receive from the responsible party, or any person or organization making payment on behalf of the responsible party, including first party, underinsured and uninsured motorist coverage. The lien will be in the amount of benefits provided or paid by us for the treatment of the condition for which the third party is responsible.

2. You agree to notify us, in writing, within 60 days of your claim against the responsible party and to take such action, furnish such information, cooperate generally, and execute any documents as we may require to facilitate enforcement of our rights.

Exclusively at our option and choice, and without any waiver of any other rights of the Group Plan, in the event of prejudice, non-cooperation or breach of this Group Plan, we may withhold, deduct or retract payments to or on behalf of the member.

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DUPLICATION OF BENEFITS/OTHER INSURANCE

This provision is intended to prevent overpayment or duplication of benefits under this Group Plan when other health care coverage provides the same benefits. It applies when a person is covered by us and has, or is entitled to, benefits as a result of their injuries from any other coverage including, but not limited to, first party uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers compensation settlement or awards, other group coverage (including student plans), direct recoveries from liable parties, premises medical pay or any other insurer providing coverage that would apply to pay your medical expenses, except other group health carriers in which case coverage will be determined under Coordination of Benefits.

Where there is such coverage, we will not duplicate other coverage available to the member and shall be considered secondary, except where specifically prohibited. Where double coverage exists, we shall have the right to be repaid from whomever has received the overpayment to the extent of the duplicate coverage.

This provision applies whether or not the member has made a claim under other applicable coverage. When applicable, the member is required to provide us with authorization to obtain information about the other coverage available, and to cooperate in the recovery of overpayments from the other coverage, including executing any assignment of rights necessary to obtain payment directly from the other coverage available.

COOPERATION REQUIRED

The member shall cooperate by providing information and executing any documents to preserve our right and shall have the affirmative obligation of notifying us that claims are being made against responsible parties to recover for injuries for which we have paid. If the member enters into litigation or settlement negotiations regarding the obligations of the other party, the member must not prejudice, in any way, our rights to recover an amount equal to any benefits we have provided or paid for the injury or sickness. Failure of the member to provide us such notice or cooperation, or any action by the member resulting in prejudice to our rights will be a material breach of this Group Plan and will result in the member being personally responsible to make repayment. In such an event, we may deduct from any pending or subsequent claim made under the Group Plan any amounts the member owes us until such time as cooperation is provided and the prejudice ceases.

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PROVISIONS APPLICABLE TO MEDICARE ELIGIBLES

DEFINITIONS

Here are some definitions of words used in this provision.

MEDICARE PART A means the Social Security program which provides hospital insurance benefits.

MEDICARE PART B means the Social Security program which provides medical insurance benefits.

For the purposes of determining benefits provided for a member who is eligible to enroll for Medicare Part B, but does not, we assume the amount provided under Medicare Part B to be the amount the member would have received if he or she had enrolled for it.

A member is considered to be eligible for Medicare on the earliest date coverage under Medicare could become effective for him or her.

INTEGRATION WITH MEDICARE

The way in which services under the Group Plan are provided or paid for a member who is eligible for Medicare is as follows. If services are provided directly by the Group Plan, we then have the right to recover the full amount of all Medicare benefits the member is entitled to receive, whether or not the member is actually enrolled for them. The member should authorize payment of Medicare benefits directly to us for services rendered. If the member does not authorize direct payment, he or she is responsible to us for the reasonable value of the services rendered. The member is also responsible to us for the reasonable value of all Group Plan services reimbursable by Medicare if the member is not enrolled for all benefits he or she is entitled to receive.

If the member receives covered services from a non-participating provider, the way in which covered services are paid for a member who is age 65 or older and eligible for Medicare is shown below.

1. If services are received which are covered by both the Group Plan and Medicare Part A, we pay for those services which exceed the amount payable by Medicare Part A.

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2. If services are received which are covered by both the Group Plan and Medicare Part B, we reduce our covered services by the amount of benefits provided for those covered services by Medicare Part B.
3. Any co-payment amount of the Group Plan will apply only to covered services received for prescription drugs and nurses.

For a member who is under age 65 and eligible for Medicare, the services provided by the Group Plan will be reduced so that no more than 100% of all of the services received are provided jointly by the Group Plan and Medicare.

When an employer employs 100 or more persons, the services of the Group Plan will be provided or paid first for a member who is under 65 and eligible for Medicare. The benefits of Medicare will be paid second.

TEFRA OPTIONS

When an employer is subject to the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA), TEFRA allows actively working covered employees age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options if the employee is: age 65 or older; and eligible for Medicare.

OPTION 1 - The services of the Group Plan will be provided or paid first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. You and your dependents, if any, will not be covered by the Group Plan.

The employer must provide you, and each covered spouse, with the choice to elect one of these options at least one month before you, or the covered spouse, becomes age 65. All new employees and newly covered spouses age 65 and older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent who is under age 65.

Under the TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the Group Plan differs for each category.

CATEGORY 1 Medicare Eligibles are:

1. actively working covered employees age 65 or older who choose Option 1;
2. the age 65 or older covered spouses; and
3. age 65 or older covered spouses of actively working covered employees who are under age 65.

CATEGORY 2 Medicare Eligibles are any other covered persons entitled to Medicare, whether or not they enrolled for it. This category includes, but is not limited to:

1. retired employees and their spouses; or
2. covered dependents of a covered employee, other than his or her spouse.

CALCULATION AND PROVISION OF SERVICES

For members in Category 1, services are provided or paid by the Group Plan without regard to any benefits paid by Medicare. Medicare will then determine its benefits.

For members in Category 2, if services are provided directly by the Group Plan, we then have the right to recover the full amount of all Medicare benefits the member is entitled to receive, whether or not the member is actually enrolled for them. The member should authorize payment of Medicare benefits directly to us for services rendered. If the member does not authorize direct payment, he or she is responsible to us for the reasonable value of the services rendered. The member is also responsible to us for the reasonable value of all Group Plan services reimbursable by Medicare if the member is not enrolled for all benefits he or she is entitled to receive.

If services are received by a member in Category 2 from a non-participating provider, Medicare benefits are paid before any services are paid by the Group Plan. The covered services of the Group Plan will then be reduced by the full amount of all Medicare benefits the member is entitled to receive, whether or not they are actually enrolled for them.

PROVISIONS FOR REIMBURSEMENT OR PAYMENT OF SERVICES

GROUP PLAN ON A DIRECT SERVICE BASIS

We provide or arrange for services to be received from participating providers on a direct service basis. If you receive services from a participating provider, we will pay the provider directly for all care you receive. You will not have to submit a claim for payment.

In the event you elect to use a non-participating provider or require medical emergency services from a non-participating provider or if we refer you to a non-participating provider, we will attempt to arrange for direct payment to that non-participating provider. If the non-participating provider refuses direct payment, you will be reimbursed for the cost of the services. You will not be reimbursed for more than the reasonable charges for the cost of the services.

The following provisions apply in the event you need to file a claim.

WE MUST BE NOTIFIED

Notice of a claim must be given to us. The notice must be in writing. Any claim will be based on the written notice. The notice must be received by us within 15 months after the start of the loss on which the claim is based. If notice is not given in time, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the notice within the 15 month period and that notice was given as soon as possible, the claim will not be reduced or invalidated.

The member must follow the procedures outlined in the Schedule of Medical Emergency Coverage at Non-Participating Providers in order to have care rendered by a non-participating provider covered as though it were provided by a participating provider. After we have been notified, the member will be advised as to how the cost of the care will be paid.

WE FURNISH CLAIMS FORMS

After we receive written notice of claim, we provide claim forms. This form should be furnished within 15 days after we receive written notice. If we fail to furnish this form within 15 days, the claimant can meet the time period shown below for submitting proof of loss by submitting written proof which explains the reasons for the claim. Written proof should establish facts about the claim such as occurrence, nature and extent of the loss involved.

WHEN TO FILE PROOF OF LOSS

Participating providers are responsible for submitting claims for covered expenses directly to us on the member's behalf. Health care providers who have entered into a reimbursement agreement with us have agreed not to bill you for an amount greater than the difference between the Reasonable charges and the benefit amount paid by us. You will need to complete and sign all necessary papers and authorize participating providers to release those medical records which may be necessary to complete the processing of your claim. Benefit payments for covered services received from a participating provider will be forwarded directly to the provider.

Written proof of loss must be given to us within 15 months after the date of the loss for which claim is made. If proof of loss is not submitted and received by us within the required time period, the claim may be reduced or invalidated. If it can be shown that it was not reasonably possible to submit the proof within the time period and that the proof was submitted as soon as possible, the claim will not be reduced or invalidated.

WE MAY EXTEND TIME LIMITS

If the time limit we allow for giving notice of claim or submitting proof of loss is less than the law permits in the state where the claimant lives, we extend our time limits to agree with the minimum period specified by that state's laws. The law must exist at the time the Group Plan is issued.

WHEN WE PAY

We will pay for covered services provided after the member has made any required co-payments. No covered services are payable for charges which are discounted, waived or rebated by a provider of services simply because the member is covered. We have the right to recover from a provider of services or from a member any excess covered services paid for charges which were discounted, waived or rebated.

If a member dies while covered services remain unpaid, we may choose to pay up to $3,000, or the amount required by state law, to:

1. any person or persons related to the member by blood or marriage who appears to be entitled to the payments; or
2. the executors or administrators of the member's estate.

We will be discharged of liability to the extent of any such payments made in good faith.

If any person to whom payment is to be made is a minor or, in our opinion, not able to give a valid receipt for any payment due him or her, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed his or her custody and support.

OUR RIGHT TO REQUIRE MEDICAL EXAMS

We have the right to require that a medical exam be performed on any claimant for whom a claim is pending as often as we may reasonably require. If we require a medical exam, it will be performed at our expense.

TIME OF PAYMENT OF CLAIMS

Claims for covered services will be paid when we receive proper written proof of loss.

LEGAL ACTIONS AND LIMITATIONS

No action at law or in equity may be brought to recover under the Group Plan until at least 60 days after written proof of loss has been filed with us. If action is to be taken after the 60 day period, it must be taken within the applicable statute of limitations in the state where the claimant lives.

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GRIEVANCE PROCEDURE

There are situations when members are dissatisfied with Plan services. Such complaints will be handled in a timely manner.

The person responsible for the maintenance of records and for the supervision of the grievance process is the Executive Director/ Designee. A specific set of records will be maintained to document grievances filed. Records will include reason for grievance, date filed, consequent actions and final disposition. They will be centrally maintained by the Grievance Manager.

The Plan will encourage members to resolve individual problems without initiation of a formal grievance procedure by contacting the Customer (Member) Services Representative for verbal resolution. Refer to your I.D. card for the Customer (Member) Service phone number. Grievances must be submitted within 30 days of occurrence, unless good cause can be shown. The Customer (Member) Services Representative must respond to the complaint within three working days of the submission.

In the event the grievance has not been settled at the informal level and the member is still dissatisfied, he or she will be advised to appeal the decision in writing to the Plan's Grievance Manager. In the case of a medical or quality care grievance, the investigation will include referral to a Physician Advisor for consultation, but the process will remain the same. The Plan's Grievance Manager will provide written acknowledgment of receipt of the grievance to the member within five working days; the grievance will be investigated and a response sent to the member no later than 30 working days following the initial filing of appeal with the Plan Grievance Manager. The member of any interested party may submit written data which will remain part of the file.

If the member is not satisfied with the response, he or she may appeal directly to the Plan's Grievance Committee. The member will be advised in writing of his or her right to appeal the decision. The Grievance Committee shall have written guidelines for investigating grievances and conducting informal hearings. As before, receipt of the grievance will be acknowledged within five working days by the Grievance Committee and resolution suggested within 30 working days. If the member remains dissatisfied with the decision of the Grievance Committee, he or she will be advised of the right to appeal to the Insurance Commissioner. The Plan will cooperate with the Commissioner and the member during the appeal.

HHS01EX1

HEALTH SERVICES AGREEMENT

SERVICES WE PROVIDE OR PAY

Each member is entitled to receive the covered services described below. All such covered services:

1. must be medically necessary as a result of sickness or injury unless specified otherwise;
2. must be received from or provided to a member under the orders, direction and approval of a physician;
3. are subject to the exclusions and limitations described elsewhere in this agreement;
4. are subject to any co-payment amounts or percentages stated in the Co-Payment Schedule; and
5. must not exceed reasonable charges for the services.

Co-payments and maximum amounts, if any, for each covered service are shown in the Copayment Schedule. We calculate co-payments by applying the dollar amount or percentage to net charges. Net charges are defined as gross billed charges less any discounts or fee negotiations that may have been arranged with participating providers. Gross charges means the amount the provider charges without giving consideration to any of the discounts which we have arranged to receive from the provider.

We will pay participating physicians for covered expenses in accordance with the fee schedules of reasonable charges established between the participating physicians and us. For services rendered by participating physicians, the dollar amount of the co-payment or co-payment percentage that is your responsibility is calculated based on the fee schedule of the participating physician rendering the services. For services rendered by non-participating physicians, the dollar amount of the deductible or benefit percentage is calculated based on a reimbursement schedule established by us and agreed to by your employer. When using a non-participating physician, you are also responsible for any charges that exceed this reimbursement schedule and any non-covered services.

Services are deemed to be received on the date a covered service is performed or furnished. A service that is provided or paid as a covered service under a particular section of the Group Plan will not be considered a covered service under any other section of the Group Plan unless specified otherwise. A service will not be covered if it is received after your coverage under the Group Plan is terminated unless it is required to be covered by state law.

THE CO-PAYMENT AMOUNT

If a member receives covered services, services are provided or paid after any co-payment amount has been paid. There is an individual co-payment amount and a family co-payment amount. After the family co-payment amount has been met, no further co-payment amount is required for the remaining members in that family for those services for the remainder of the period shown in the Co-Payment Schedule. The co-payment amount for each member and the family co-payment amount are shown for all services, or for a portion of services, in the Co-Payment Schedule. They must be satisfied during the period shown for them. If a member receives services in a non-participating hospital, the non-participating hospital co-payment amount must be satisfied first, then the calendar year co-payment amount.

If two or more members of the same family are injured in the same accident and receive covered services for those injuries, only one co-payment amount will be deducted from the total covered services resulting from the accident in the calendar year in which the accident occurs.

In addition, only one co-payment amount will be deducted from the total covered services received as a result of a multiple birth of two or more dependents. The covered services must be received in the same calendar year as the birth and result from:

1. premature birth;
2. an abnormal congenital condition; or
3. an injury or sickness occurring within 30 days after the birth.

CO-PAYMENT LIMIT

The co-payment limit is the amount of covered services, excluding amounts applied to the co-payment amount, that must be paid by each member in the period shown in the Co-Payment Schedule before we increase the co-payment percentage we provide or pay. After the co-payment limit has been satisfied, covered services for the member are provided or paid at the rate of 100% for the rest of the period shown for them in the Co-Payment Schedule.

There is also a family co-payment limit. After the family co-payment limit has been satisfied, covered services for members in that family are provided or paid at the rate of 100% for the rest of the period shown for them in the Co-Payment Schedule.

The co-payment limit for each individual and each family is shown in the Co-Payment Schedule. However, covered services provided or paid in connection with psychiatric disorders, alcoholism or drug abuse will be provided or paid as shown in the Co-Payment Schedule for them and will not apply towards the satisfaction of the individual or family co-payment limits.

LIFETIME MAXIMUM COVERED SERVICES AMOUNT

The total amount of covered services we pay on behalf of and/or provide to a member in his or her lifetime will not exceed the lifetime maximum covered services amount shown in the Co-Payment Schedule.

If a member uses any portion of his or her lifetime maximum covered services amount, we will furnish the used portion again on each January 1, up to a maximum of $1,000. The $1,000 will be applied to covered services received after the date of reinstatement. Once a lifetime maximum covered services amount has been reached, services will not be reinstated.

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PRE-AUTHORIZATION PROVISIONS

All coverage provided under the Group Plan must be for services and supplies that are medically necessary. In order to determine whether services and supplies meet guidelines for medical necessity, they must be authorized by us in advance.

The member is responsible for alerting his or her physician regarding the need for prior approval. The identification card will alert the physician that pre-authorization is required and will show the telephone number to call to obtain the appropriate authorization. If prior approval of services or supplies is not obtained, coverage may be reduced or not paid at all.

WHEN EMERGENCY HOSPITALIZATION IS REQUIRED

If a medical emergency requires that a member be admitted to a hospital, we must be advised by the hospital of the admission immediately. We will then review the medical necessity of the admission. If the member has been admitted to a non-participating hospital, and it has been determined that the member's condition has stabilized sufficiently to allow the member to be transferred safely to a participating hospital, we will request that the member and the member's physician approve the transfer. If the transfer is not approved, all services, supplies and any days of hospital confinement at the non-participating hospital beyond the date the member's medical emergency was stabilized are not covered.

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MEDICAL SERVICES

Covered Medical Services include the following if they are received by a member as the result of an injury or sickness which occurs while covered under the Group Plan. Services are subject to the applicable co-payment amount or percentage shown on the Co-Payment Schedule.

1. Daily room and board and other medically necessary services and supplies provided while a member is hospital confined.
2. Routine nursery care for a newborn child for up to a maximum of 10 days following birth.
3. Confinement in an intensive care, cardiac care or neonatal unit, provided in place of services covered in (1) above.
4. Services and supplies furnished by an ambulatory surgical center.
5. Medical care and treatment of an injury or sickness provided by a physician.
6. Surgical procedures performed on an inpatient or outpatient basis.
7. Obstetrical services received on an inpatient or outpatient basis, including medically necessary prenatal and post-natal care of the mother.
8. Physician's care of a newborn child while the child is hospital confined immediately following birth for up to 10 days.
9. Anesthesia administered by a physician or certified registered anesthetist attendant to a surgical procedure.
10. Radiation therapy received on an inpatient or outpatient basis.

MEDICAL SERVICES (CONTINUED)

11. Consultation charges requested by the attending physician during a hospital confinement. This benefit is limited to one consultation by any one consultant per specialty during a hospital confinement.

12. Surgical assistance provided by a physician, when medically necessary. The benefit for surgical assistance will be 20% of the reasonable charge for the chief surgeon.

13. Inhospital medical services furnished by the attending physician to a hospital confined member.

14. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

15. Outpatient medical care and treatment.

16. Private duty nursing in a hospital or in the home, by a nurse.

17. Radium therapy, x-ray treatments and examinations (other than dental x-rays), microscopic tests or any lab tests or analyses made for diagnosis or treatment; including the following performed for breast cancer screening:

    a. One screening mammogram for women age 35 through 39;

    b. One mammogram every two years for women age 40 through 49; and

    c. One mammogram per year for women age 50 and over.

18. The following services and supplies:

    a. administration of whole blood and blood components;

    b. casts, splints, trusses, crutches and braces (excluding replacement braces or dental braces);

    c. initial placement of a medically necessary prosthesis and its supportive device. We will also cover the replacement of such prothesis if it is determined by the member's physician to be necessary because of growth or changes;

    d. oxygen or rental of equipment for administration of oxygen;

MEDICAL SERVICES (CONTINUED)

    e. the initial pair of eyeglasses or contacts needed due to cataract surgery or an accident that occurs while covered under the Group Plan if the eyeglasses or contacts were not needed prior to the accident; and

    f. the purchase or rental of medically necessary durable medical equipment. If the cost of renting the equipment is more than a member would pay to buy it, only the cost of the purchase is considered to be a covered service. In either case, total covered services for durable medical equipment shall not exceed its purchase price and purchase or rental will be at our option. We do not provide or pay for equipment or devices not specifically designed and intended for the care and treatment of an injury or sickness.

19. Services of a speech therapist or pathologist to restore speech loss or impairment resulting from trauma, stroke or a surgical procedure while covered under the Group Plan. Services for any and all therapy covered under the Group Plan will be subject to a combined limit of 20 visits per calendar year.

20. Services of a licensed audiologist to determine and measure hearing loss which occurred while covered under the Group Plan. Services for any and all therapy covered under the Group Plan will be subject to a combined limit of 20 visits per calendar year.

21. Services of a licensed physical therapist for purposes of training to aid restoration of normal physical functions lost due to trauma, stroke or a surgical procedure while covered under the Group Plan. Services for any and all therapy covered under the Group Plan will be subject to a combined limit of 20 visits per calendar year.

22. Professional ambulance services.

MEDICAL SERVICES (CONTINUED)

HOME HEALTH CARE SERVICES

HOME HEALTH CARE AGENCY means a home health care agency or a hospital which meets all of the following requirements.

1. It must primarily provide skilled nursing services and other therapeutic services under the supervision of physicians or registered nurses.
2. It must be run according to rules established by a group of professional medical people, including physicians and nurses.
3. It must maintain clinical records on all patients.
4. It must be licensed by the jurisdiction where it is located, if licensure is required. It must be run according to the laws of that jurisdiction which pertain to agencies providing home health care.

HOME HEALTH AIDE means a person who provides care of a medical or therapeutic nature. The home health aide must report to and be under the direct supervision of a home health care agency.

HOME HEALTH CARE PLAN means a plan of care and treatment of a member in his or her home. To qualify, the home health care plan must be established and approved by a physician. The physician must also certify that the member would otherwise require confinement in a hospital or skilled nursing facility if he or she did not have the care stated in the home health plan.

Services are payable for covered expenses incurred in connection with a home health plan. The home health care services must begin within 30 days after a member's discharge from a hospital or skilled nursing facility or may be provided in lieu of an admission. If confined, home health care must be for the same condition which caused the confinement or a related condition. If home health care services are to be provided instead of a hospital admission, the services must receive prior approval from us. All home health care services and supplies must be provided on a part-time or intermittent basis to an member in conjunction with a home health care plan.

Home health care services include:

1. nursing care by or under the supervision of an R.N. or L.V.N.;
2. physical, occupational, respiratory or speech therapy, medical social work, nutrition services and home health aide services;
3. medical appliances and equipment, laboratory services and special meals, if such services and supplies would have been covered by the Group Policy if the member had been in a hospital;
4. services of a home health aide including extension of therapy services, personal care, ambulation and exercise, household services essential to health care, assistance with medications that are ordinarily self-administered, reporting changes in the member's condition and needs and completing appropriate records.

MEDICAL SERVICES (CONTINUED)

The Co-Payment Schedule shows the amount or percentage payable and the maximum number of visits allowed by a representative of a home health care agency. A combination of three (3) visits in a 24 hour period for all types of care will be considered a covered expense. A visit by any registered or licensed professional representative of a home health care agency, other than a home health aide, will be one home health care visit. A visit by a home health aide of four hours or less will be counted as one visit.

EXTENSION OF HOME HEALTH CARE PLAN

Benefits for home health care may be extended beyond the initial number of visits. A request for an extension must be made by a physician who certifies, in writing, the medical necessity of the additional visits. When a request for an extension is granted, only a limited number of additional home health care visits will be authorized. When that extension is exhausted, an additional extension may be requested. However, the total number of initial visits and extended visits may not exceed 100 visits per calendar year. NO SERVICES WILL BE PAYABLE for extended home health care visits if we do not approve the extension.

MEDICAL SERVICES (CONTINUED)

PRE-ADMISSION TESTING SERVICES

There are no deductibles and co-payment requirements for pre-admission tests that meet all of the following requirements.

1. The admission to the hospital or the scheduled outpatient surgery is confirmed in writing by the attending physician before the testing occurs.
2. The tests must be performed within 7 days before admission to the hospital or the outpatient surgery.
3. The tests must be ordered by the attending physician.
4. The tests are performed in a facility accepted by the hospital in place of the same tests which would normally be done while hospital confined.
5. The tests are not duplicated in the hospital.
6. The member is subsequently admitted to the hospital or the outpatient surgery is performed, unless a hospital bed is unavailable or there is a change in the member's health condition which would preclude the procedure.

If these requirements are not met, the co-payment amount or percentage for Medical Services will apply to the pre-admission testing services.

PRE-ADMISSION TESTS means laboratory tests or x-ray examinations done on an outpatient basis in a hospital or other facility accepted by the hospital within seven days before a planned hospital confinement or outpatient surgery.

MEDICAL SERVICES (CONTINUED)

PSYCHIATRIC DISORDERS, ALCOHOLISM AND DRUG DEPENDENCY SERVICES

Services provided by a physician, or a hospital or a psychiatric treatment program while a member is undergoing treatment for psychiatric disorders, alcoholism or drug dependency are covered as follows.

1. Inpatient Services - Services received by a member while confined as a registered bed patient in a hospital or psychiatric treatment program will be considered covered services. The confinement must be pre-authorized by us and our Psychiatric Designee. Covered services are limited to the maximum number of inpatient days per calendar year shown on the Co-Payment Schedule. The number of days shown will be reduced by confinement in either a participating or non-participating facility provider.
2. Outpatient Services - Services received by a member while not confined in a hospital or outpatient treatment program will be considered as covered services. Covered services are limited to the maximum number of visits per calendar year and the calendar year maximum benefit shown on the Co-Payment Schedule. The number of visits shown will be reduced by visits at either a participating or non-participating provider. The outpatient treatment must be authorized by us and our Psychiatric Designee.
3. Co-Payment Amount and Percentage - All services received for the outpatient treatment of psychiatric disorders, alcoholism and drug dependency are subject to the co-payment amounts or percentages shown on the Co-Payment Schedule.

MEDICAL SERVICES (CONTINUED)

SECOND SURGICAL OPINION

No co-payment amount or percentage will apply to services received by a member for a second surgical opinion, after he or she has received a recommendation to have elective surgery which is covered under the Group Plan if:

1. the consulting physician personally examines the member and we receive a copy of the written opinion; and
2. the consulting physician does not perform the surgery to correct the condition for which the original recommendation was given.

If both the conditions stated above are not met, the Medical Services co-payment amount or percentage will be applied to the second opinion.

If the second opinion does not confirm the original recommendation, the member may consult another physician for a third opinion under the same terms and conditions as stated above for a second surgical opinion.

SECOND SURGICAL OPINION means a consultation with a Board Certified surgeon after a member has received a recommendation to have surgery. This consultation includes the physical examination, laboratory work and X-rays not previously performed by the original surgeon. The consulting surgeon must not be affiliated in practice with the surgeon who first recommended surgery.

MEDICAL SERVICES (CONTINUED)

SKILLED NURSING FACILITY SERVICES

Services received from a skilled nursing facility for room and board, and necessary services, supplies and routine care are considered covered services. The member must be confined to the skilled nursing facility as an inpatient, based upon the written recommendation of a physician. The confinement must begin within 14 days after a discharge from hospital confinement. In addition, the confinement must be due to the same condition which caused the hospital confinement or a related cause. If a member is discharged from the skilled nursing facility and again becomes an inpatient in such facility within 14 days of the original discharge, it is considered one period of confinement.

The maximum amount or co-payment percentage payable and the length of time for which we cover these services is shown on the Co-Payment Schedule.

SKILLED NURSING FACILITY means a licensed institution (other than a hospital, as defined) which meets all of the following requirements.

1. It must provide treatment to restore the health of sick or injured persons.
2. The treatment must be given by or supervised by physicians. Nursing services must be given by or supervised by registered nurses.
3. It must be eligible to qualify as a skilled nursing facility and as a provider of services under Medicare.
4. It must not primarily be a place of rest, a nursing home or a place of care for senility, drug addiction, alcoholism, mental retardation, psychiatric disorders, chronic brain syndromes or a place for the aged.
5. It must be licensed by the laws of the jurisdiction where it is located. It must be run as a skilled nursing facility as defined by those laws.

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MEDICAL SERVICES (CONTINUED)

HOSPICE SERVICES

Hospice services must be received for a hospice care program which is submitted in writing and approved by us. The member must submit his or her intent to enroll in a hospice care program approved by us in writing. Hospice services are subject to the applicable co-payment amount and percentage. The most we cover for inpatient and outpatient treatment and bereavement counseling received in a hospice care program is shown on the Co-Payment Schedule.

All outpatient hospice counseling must be received within a 12 month period. Services for bereavement counseling will be covered for counseling received during the 6 month period following the member's death.

HOSPICE CARE PROGRAM means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill family member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at- home or inpatient care. The hospice must be licensed by the laws of the jurisdiction where it is located and must be run as a hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illness and, as estimated by a physician, are expected to live less than 6 months as a result of that illness.

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ORGAN TRANSPLANT BENEFIT

Contrary to any limitations on organ transplants contained in the Group Plan, we will pay benefits for covered organ transplant expenses, as defined below, incurred by a member for an organ transplant approved by us at a facility approved by us, subject to those conditions and limitations described below.

TRANSPLANT means pre-transplant, transplant inclusive of any chemotherapy and associated services and post-discharge services, and treatment of complications after transplantation. We will pay benefits only for services, care, and treatment received for or in connection with the approved transplantation of the following human organs:

1. Heart;
2. Liver, for the following diagnoses: Biliary Atresia, Primary Biliary Cirrhosis, Primary Sclerosing Cholangitis, Postnecrotic Cirrhosis Hepatitis B Surface Antigen Negative, Alcoholic Cirrhosis (only if 6 months abstinence from alcohol is documented), Alpha-1 Antitrypsin Deficiency Disease, Wilson's Disease, Primary Hemochromatosis. Diagnoses not covered for liver transplantation include, but are not limited to, the following diagnoses: Primary or Metastatic Cancer of the Liver, Hepatitis B Surface Antigen Positive, Secondary Biliary Cirrhosis, Lupus Hepatitis or Autoimmune Hepatitis, Cytomegalovirus Hepatitis, Epstein-Barr Virus Hepatitis, Budd-Chiari Syndrome, Veno-Occlusive Disease, Liver damage caused by chemicals, toxins, or external agents, Alcoholic Cirrhosis without 6 months abstinence from Alcohol;
3. Kidney;
4. Bone marrow (allogeneic, autologous and peripheral blood stem cells) but only for certain types of Leukemia, Neuroblastomas, Lymphomas, Ewing's Sarcoma, Aplastic Anemia, Wiskott-Aldrich Sydrome, Severe Combined Immuno-Deficiency Syndrome. We will not cover bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of cancers or diseases of the brain, breast, bone, large bowel, ovary, small bowel, testicle, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus. We will not cover bone marrow transplants for any congenital, genetic or metabolic disorders affecting or originating in the blood-forming (hematopoietic) system except as stated above as covered.

Corneal transplants, which are tissues rather than organs, do not required prior approval.

As used in this document, the term "bone marrow transplant" means human blood precursor cells which are administered to a patient following ablative or myelosuppressive therapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the harvesting, the transplantation and the chemotherapy components.

For a transplant procedure to be considered approved for this Transplant Benefit, prior approval from our Medical Affairs Department is required in advance of the procedure. You or your Physician must notify us in advance of your initial evaluation for the procedure in order for us to determine if the transplant services will be covered. For approval of the transplant itself, our Medical Affairs Department must be given the opportunity to evaluate the clinical results of the evaluation. Approval will be based on written criteria and procedures established by our Medical Affairs Department. If approval is not given, benefits will not be provided for the transplant procedure as defined above.

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EXCLUSIONS

No benefit is payable for or in connection with a transplant if:

1. The organ or diagnosis involved is not listed in this section of the Group Plan. Transplants that are not covered include, but are not limited to, islet cells, lung(s), heart-lung combination, pancreas, kidney-pancreas combination, bowel, stomach, thymus, and pituitary. Bone Marrow and liver transplants are also excluded except as stated as covered in this Group Plan.
2. Our Medical Affairs Department is not contacted for authorization prior to referral for transplant evaluation of the procedure.
3. Our Medical Affairs Department does not approve coverage for the procedure, based on our established criteria.
4. The transplant procedure is performed in a facility that has not been designated by our Medical Affairs Department as an approved transplant facility.
5. Expenses are eligible to be paid under any private or public research fund, government program, or other funding program, whether or not such funding was applied for or received.
6. The expense relates to the transplantation of any non-human organ or tissue.
7. The expense relates to the donation or acquisition of an organ for a recipient who is not covered by us.
8. A denied transplant is performed; this includes the transplant procedure, follow up care, immumo-suppressive drugs, and complications of such transplant.

The following services/supplies/expenses are also not covered:

1. Artificial heart devices used as a bridge to transplant.
2. Drugs used in connection with diagnosis or treatment leading to a transplant when such drugs have not received FDA approval for such use.

Once the transplant procedure is approved, our Medical Affairs Department will advise the member's physician of those facilities that have been approved for the type of transplant procedure involved. Benefits are payable only if the pre-transplant services, the transplant procedure and post-discharge services are performed in an approved facility.

COVERED EXPENSES

For approved transplant procedures, and all related complications, we will cover only the following expenses:

1. Hospital expenses and physician's expenses will be paid under the Hospital Benefit and Physician's Benefit in this Group Plan in accordance with the same terms and conditions as we will pay benefits for care and treatment of any other covered injury or sickness.
2. Transportation costs for the member to and from the approved facility where the transplant is to be performed if the facility is more than 100 miles from the member's home.
3. Direct, non-medical costs for one member of the member's immediate family (two members if the patient is under age 18 years) for (a) transporation to and from the approved facility where the transplant is performed, but no more than one round trip per person per transplant and (b) temporary lodging at a prearranged location during the member's confinement in the approved transplant facility, not to exceed $75 per day. Direct, non-medical costs are only payable if the member lives more than 100 miles from the approved transplant facility. There is a $5000 maximum for these direct, non-medical expenses.
4. Organ acquisition and donor costs. However, donor costs are not payable under the Group Plan if they are payable in whole or in part by any other group plan, insurance company, organization or person other than the donor's family or estate.

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EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITION LIMITATION: Services for pre-existing conditions are not covered until the earlier of the following dates:

1. the date the member has been free of treatment for the pre-existing condition for three consecutive months; or
2. the date the member has been covered by the Group Plan for 12 consecutive months.

PRE-EXISTING CONDITION means a condition which:

1. is caused by an injury or sickness; and
2. required a member, during the three months prior to becoming covered, to:
   a. consult a physician;
   b. seek diagnosis or advice or receive medical care or treatment;
   c. undergo hospital admission or physician visits for testing or diagnostic studies; or
   d. obtain services, supplies, prescription drugs or medicines.

OTHER LIMITATIONS AND EXCLUSIONS:

Unless specifically stated otherwise, no services will be provided or paid for or on account of:

1. a sickness or injury which is covered under any Workers' Compensation or similar law.
2. care and treatment given in a hospital owned or run by any federal, state, or other government, unless the member is legally required to pay for such care and treatment. However, care and treatment provided by military hospitals to armed services retirees and their dependents is not excluded.
3. any charge which would not have been made if the member had no coverage or any charge the member would not be legally required to pay.

4. sickness or injury for which the member is in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.

5. education or training; medical services provided by the member's parent, spouse, brother, sister, or child.

6. experimental or investigational drugs or substances not approved by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications; or drugs labeled: "Caution-limited by Federal law to investigational use".

7. prescription drugs, including insulin and syringes, vitamins, birth control pills unless medically necessary for a medical condition and non-prescription drugs or medicines.

8. treatment, services, supplies or surgery that is not medically necessary.

9. the purchase or fitting of hearing aids or advice on their care; implantable hearing devices.

10. weekend non-emergency hospital admissions.

11. in-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; sex change services; or reversal of elective sterilization.

12. any drug, biological product, device, medical treatment, or procedure which is experimental or investigational that is defined in this Group Plan; any drug, biological product, device, medical treatment or procedure which is not covered as experimental or investigational (or similar) by the HCFA Medicare Coverage Issues Manual; any drug, biological product, or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which lacks such approval at the time of its use or proposed use; or, any drug or biological product categorized as a Treatment Investigational New Drug (IND) by the U.S. Food and Drug Administration or as a Group C Treatment Protocol drug by the U.S. National Cancer Institute at the time of its use or proposed use. Specifically excluded are: ambulatory blood pressure monitor, refractive keratoplasty or radial keratotomy, positron emission tomography (PET) scans, transurethal balloon dilation of prostate, immunotherapy for recurrent abortion, chemonucleolysis, biliary lithotripsy, home uterine activity monitor, immunotherapy for food allergy, and percutaneous lumbar discectomy.

13. plastic, cosmetic or reconstructive surgery unless medically necessary as the result of an injury or tumor. The injury, or the initial tumor surgery, must occur while insured under the Group Plan. Such surgery will also be covered if an objective functional impairment is present. An objective functional impairment is defined as a direct measurable reduction of physical performance of an organ or body part. The presence of a psychological condition will not entitle a member to coverage for plastic, cosmetic or reconstructive surgery unless all other conditions are met.

14. services and supplies for dental services, treatment of teeth or periodontium, oral surgery, or any other orthodontic treament regardless of medical neccesity, unless (a) the services and supplies are for the treatment of temporomandibular joint (TMJ) syndrome/dysfunction or craniomandibular jaw disorder (CMJ); or (b) the services are required due to the surgical removal of a tumor or lesion in the mouth, or (c) the services are received in connection with an injury to sound natural teeth or jaw sustained while the person is covered by the Group Plan if (1) the care and treatment is provided within 12 months from the date of the injury, (2) the member is continuously covered under the Group Plan from the date of the injury to the date care and treatment is received, and (3) the injury was not the result of biting or chewing. We will not cover dental braces, dental implants or any treatment related to the preparation or the fitting of dentures.

15. services and supplies for treatment of temporomandibular joint (TMJ) syndrome/dysfunction and craniomandibular jaw disorder (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices and splints.

16. diagnosis or care and treatment of: (a) weak, strained, unstable or flat feet; or (b) toenails, except removal of a nail matrix.

17. any: (a) superficial lesions of the feet, such as corns, calluses or hyperkeratoses; or (b) tarsalgia, metatarsalgia or bunion, except surgery which involves exposure of bones, tendons or ligaments.

18. for any service, supply or treatment connected with custodial care. We do not provide these services no matter who provides, prescribes, recommends or performs them. Custodial care means services designed to help a member meet the needs of daily living, whether or not he or she is disabled. These services include help in:

    a. walking or getting in or out of bed;
    b. personal care such as bathing, dressing, eating, or preparing special diets; or
    c. taking medication which the member would normally be able to take without help.

19. sickness or injury caused by: (a) war, whether or not declared, or insurrection; or (b) military service.

20. sickness or injury caused by the member's: (a) engaging in an illegal occupation; or (b) commission of or an attempt to commit a criminal act.

21. enrollment in a health, athletic, or similar club; or a weight loss or similar program.

22. purchase or rental of supplies of common household use such as: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; allergenic pillows or mattresses; or waterbeds.

23. purchase or rental of: motorized transportation equipment; escalators or elevators; saunas or swimming pools; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items.

24. convenience or personal care services such as use of a telephone or television.

25. any surgical procedure to reduce obesity.

26. elective abortion unless the physician certifies in writing that the pregnancy would endanger the life of the mother.

27. pregnancy of a child, except: complications arising from it; or for pregnancies resulting from rape or incest.

28. vision analysis, testing or orthoptic training or the purchase of eyeglasses or contact lenses.

29. spinal manipulations.

30. services and supplies which are (a) rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services, (b) extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation, or (c) for marriage counseling, when such services extend beyond the period necessary for short-term evaluation or crisis intervention, or (d) for mental illnesses which, according to generally accepted professional standards, are not usually amendable to favorable modification.

31. acupuncture, unless:

    a. the treatment is medically necessary and appropriate and is provided within the scope of the acupuncturist's license;
    b. the insured person is referred to the acupuncturist's treatment by a licensed physician; and
    c. the acupuncture is performed in lieu of generally accepted anesthesia practices.

32. routine physical examinations, even when required by an employer, school or insurance company.

33. services related to methadone treatment and care related to a dependency created by the use of methadone.

34. court ordered treatment for psychiatric disorders, alcoholism and drug dependency.

35. any and all benefits related to organ or artificial organ transplants or organ donations, except as specifically provided in the Organ Transplant Benefit section of this Group Plan.

36. maintenance care, which consists of services and supplies furnished mainly to:

    a. maintain, rather than improve, a level of physical or mental function; or
    b. provide a protected environment free from exposure that can worsen the member's physical or mental condition.

37. care and treatment rendered by a provider whose services are not required to be covered by state law, except as provided by the Group Plan.

38. care and treatment of complications of non-covered procedures, unless required by state law.

39. more than one prescription for the same drug or therapeutic generic medication prescribed by one or more physicians and dispensed by one or more pharmacies until at least 75% of the previous prescription has been used by the member. (Based on the dosage schedule prescribed by the physician.)

40. services provided prior to the effective date or after the termination of your coverage under the Group Plan. Coverage will be extended under the Extension of Health Services provision, if such coverage is required by state law.

EMERGENCY COVERAGE AT NON-PARTICIPATING PROVIDERS

Subject to any co-payments and maximum limitations for the services received as described in the Co-Payment Schedule for this Health Services Agreement, we will reimburse or pay on behalf of a member the emergency services expense he or she incurs for covered health services received from a non-participating provider on the same basis as covered services received from a participating provider, if we authorize the services as described in this section. Our reimbursement or payment will be reduced by any co-payments which would have been required had the services been provided by a participating provider.

All such expenses:

1. must have been incurred for medically necessary services;
2. must have been incurred or provided under the order, direction and approval of a licensed physician; and
3. must not exceed reasonable charges for the services.

Payment for emergency services received at non-participating providers will be subject to the following:

1. IN THE SERVICE AREA, the member must contact his or her physician before receiving services.

   If the member is unable to contact his or her physician, the member must go to the nearest participating hospital.

   If the member is unable to indicate a choice of hospital, or if travel to the nearest participating hospital would endanger the member, the member should:

   a. receive emergency services; and
   b. notify us of the emergency within 24 hours of the time emergency services are received, or as soon after that as is reasonably possible. Notification must include full details of the care provided and to be provided to the member.

If we then determine that the sickness or injury was not serious enough to warrant coverage as an emergency, or if the member does not notify us as described above, the services received will be payable as covered services received from a non-participating provider.

2. OUTSIDE THE SERVICE AREA: If emergency services are required and the member cannot reasonably return to the service area, the member should:

   a. receive emergency services; and
   b. notify us of the emergency within 48 hours of the time emergency services are received, or as soon after that as is reasonably possible. Notification must include full details of the care provided and to be provided to the member.

   If we then determine that the sickness or injury was not serious enough to warrant coverage as an emergency, or if the member does not notify us as described above, the services received will be payable as covered services received from a non-participating provider.

   In any event, the member is responsible for any amount we determine is in excess of reasonable charges.

3. FOLLOW-UP CARE to the emergency services must be received from participating providers as soon as it is reasonably possible to so provide the care. Care received from non-participating providers after the emergency ceases to exist will be covered as any other service received from a non-participating provider.

4. DEPENDENTS WHO ARE STUDENTS outside of the service area are subject to the terms and conditions of this Emergency Coverage at Non-Participating Providers provision.

PRESCRIPTION DRUG COVERAGE RIDER

The following terms are used in this coverage description.

FORMULARY means a list of drug products, including their strengths and appropriate dosages, that are available for use by members.

NON-PARTICIPATING PHARMACY means a pharmacy that has not entered into a service agreement with us.

PARTICIPATING PHARMACY means a pharmacy which agrees to provide service under terms set forth by us.

PHARMACIST means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

PHARMACY means a licensed establishment where prescription medications are dispensed by a pharmacist.

PRESCRIPTION means a direct order for the preparation and use of a drug, medicine or medication. This order may be given by a physician to a pharmacist for the benefit of and use by a member. The drug, medicine or medication must be obtainable only by prescription. The prescription may be given to the pharmacist verbally or in writing by the physician. The prescription must include:

1. the name and address of the member for whom the prescription is intended;
2. the type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. the date the prescription was prescribed; and,
4. the name, address and DEA number of the prescribing physician.

COVERAGE DESCRIPTION

We will cover prescription drugs that are received by the member while he or she is covered under this Prescription Drug Coverage Rider of the Group Plan as follows.

Covered prescription drugs are:

1. any drug, medicine or medication that, under Federal or state law, may be dispensed only by prescription from a physician, or any compounded prescription containing such drug, medicine or medication; and;
2. insulin, hypodermic needles or syringes on prescription.

Covered prescription drugs must:

1. be prescribed by a participating physician for the treatment of an injury or sickness;
2. be dispensed by a pharmacist; and
3. be a generic medication when both a generic and a more expensive brand name drug are available; and
4. be included in the formulary approved by us.

Contrary to any other provisions of the Group Plan, prescription drugs provided under this Prescription Drug Coverage Rider are not provided under any other provision in the Group Plan. Any prescriptions ordered or received to the extent they are in excess of any maximums covered under this Agreement are not covered under any other provision in the Group Plan.

The member's ID card must be presented to a participating pharmacy each time a prescription is filled or refilled.

PRESCRIPTION DRUG CO-PAYMENT

The prescription drug co-payment for a participating pharmacy is $5
. It must be paid by the member each time a prescription is filled or refilled. The prescription drug co-payment by the member is not covered by this or any other provision of the Group Plan.

In addition to the deductible, the member must pay the participating pharmacy 100% of the additional cost for a more expensive brand name prescription drug, which is dispensed at the request of the member or the prescribing physician, when a generic is available, unless the brand name drug is specifically authorized by the prescribing physician.

LIMITATIONS AND EXCLUSIONS

Unless specifically stated otherwise, no services are provided for:

1. any drug, medicine or medication that is consumed at the place where the prescription is given or that is dispensed by a participating physician;
2. any portion of a prescription or refill that exceeds a 34-day supply or a 100 unit dose, whichever is less;
3. prescription refills in excess of the number specified by the participating physician or dispensed more than one year from the date of the participating physician's original order;
4. the administration of covered medication;
5. prescriptions that are to be taken by or administered to the member, in whole or in part, while he or she is a patient in a hospital, rest home, skilled nursing facility, convalescent hospital, inpatient hospice facility or other facility where drugs are ordinarily provided by the facility on an inpatient basis;

6. prescriptions that may be properly received without charge under local, state or federal programs, including Workers' Compensation;
7. any drug, medicine or medication labeled "Caution–Limited by Federal Law to Investigational Use" or any experimental drug, medicine or medication, even though a charge is made to the member;
8. immunizing agents, biological serums or allergy serums;
9. any drug or medicine that is lawfully obtainable without a prescription;
10. any drug, medicine or medication received by the member before becoming covered by this Prescription Drug Coverage Rider, or after the date the member's coverage under this provision has ended;
11. therapeutic devices or appliances, including support garments, and other non-medical substances, regardless of intended use;
12. hypodermic needles or syringes, unless prescribed and dispensed in conjunction with a prescribed medication. The hypodermic needles or syringes must be dispensed at the same time as the medication and in like quantity;
13. more than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more physician and dispensed by one or more pharmacies until at least 75% of the previous prescription has been used by the member. (Based on the dosage schedule prescribed by the physician.)
14. any contraceptives, regardless of intended use;
15. injectable medication, except insulin on prescription;
16. any costs related to the mailing, sending or delivery of prescription drugs; and
17. prescriptions filled at a non-participating pharmacy, except for prescriptions required during an emergency.

CO-PAYMENT SCHEDULE

PERCENTAGE CO-PAYMENTS SHOW THE PERCENTAGE OF REASONABLE CHARGES WE WILL PAY. PARTICIPATING PHYSICIANS HAVE AGREED TO ACCEPT OUR REASONABLE CHARGE DETERMINATION AS PAYMENT IN FULL. SEE PAGE HP2108 FOR THE DEFINITION OF 'REASONABLE CHARGES.'

INDIVIDUAL LIFETIME MAXIMUM COVERED SERVICES AMOUNT ——— $1000000

MEDICAL SERVICES CO-PAYMENT AMOUNTS

Calendar Year Co-Payment Amount For Each Member ——— $150
Calendar Year Co-Payment Amount For Each Family of Members ——— $450

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE PAYABLE AFTER CO-PAYMENT AMOUNT
Room and Board and Ancillary Services at Semi-Private Room Rate		
- Participating Hospital	YES	80 %
- Non-Participating Hospital	NOT COVERED	NOT COVERED
Outpatient Non-Surgical Services		
- Participating Hospital	YES	80 %
- Non-Participating Hospital	NOT COVERED	NOT COVERED
Outpatient Surgical Services		
- Participating Hospital	YES	80 %
- Non-Participating Hospital	NOT COVERED	NOT COVERED
Pre-Admission Testing in Accordance with Group Plan Provisions	NO	100%

CO-PAYMENT SCHEDULE (CONTINUED)

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
Emergency Room Visit (Facility Charge)		
- Participating Hospital	$40	80 %
- Non-Participating Hospital	$40	80 %*

*Medical emergencies are covered at the participating hospital benefit level. No benefits are covered if there is not a medical emergency.

WAIVER OF NON-PARTICIPATING HOSPITAL EXCLUSION

Services will be covered in non-participating hospitals in the following circumstances:

HOSPITAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
- Emergency Services Rendered Outside the Service Area	- SEE PARTICIPATING HOSPITAL BENEFIT LEVELS -	
- Services Not Available at a Participating Hospital	- SEE PARTICIPATING HOSPITAL LEVELS -	

CO-PAYMENT SCHEDULE (CONTINUED)

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
Office Visits (1)		
- Participating Physician	$ 10 Co-Payment Per Visit	100%
- Non-Participating Physician	Medical Services Co-Payment	80 %
Allergy Immunizations		
- Participating Physician	$3 Co-Payment Per Visit	100%
- Non-Participating Physician	Medical Services Co-Payment	80 %
Inpatient Services (2)		
- Participating Physician	NO	80 %
- Non-Participating Physician	Medical Services Co-Payment	80 %
Outpatient Services		
- Participating Physician	NO	80 %
- Non-Participating Physician	Medical Services Co-Payment	80 %

(1) Includes emergency room visits by the physician and minor diagnostic and therapeutic procedures performed in the physician's office.

(2) If a participating physician admits you to a non-participating provider or performs outpatient surgery at a non-participating provider, coverage for Physician Services will be reduced by 20%, unless the services at the non-participating provider were required because of a medical emergency or because the service was not available at a participating provider.

CO-PAYMENT SCHEDULE (CONTINUED)

MEDICAL SERVICES	CO-PAYMENT AMOUNT APPLICABLE	OUR CO-PAYMENT PERCENTAGE AFTER CO-PAYMENT AMOUNT
Ambulance Services		
- Participating	YES	80 %
- Non-Participating	YES	60 %
Hospice Care Services		
- Inpatient	YES	$150 per day up to a maximum benefit of $3000
- Outpatient	YES	$50 per visit up to a maximum benefit of $2000
All Other Medical Services Including Services/Supplies Not Available at Participating Providers	YES	80 %

CALENDAR YEAR CO-PAYMENT LIMITS FOR PARTICIPATING HOSPITAL, ALL PHYSICIAN PROVIDERS AND MEDICAL SERVICES (Excludes any initial co-payment amounts)

Each Member $500
Each Family of Members $1500

PRE-AUTHORIZATION PENALTY

If any required pre-authorization of services is not obtained, coverage for any medically necessary services, after any applicable co-payments, will be reduced by 50%. If services are not medically necessary, no coverage is provided at all. This out-of-pocket amount may not be used to satisfy any Co-Payment Limits.

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HUMANA HEALTH PLAN, INC.

ACCIDENT RIDER

This Rider modifies your coverage as follows:

We will provide or pay 100% of the first $200 of covered services received for the treatment of an accidental injury. Treatment must be provided within 72 hours of the injury.

We will also cover related services received within 90 days of the date the injury occurred.

This coverage is not subject to a co-payment amount.

Any services provided or paid under this Rider are not covered under any other section of the Group Plan.

HUMANA HEALTH PLAN, INC.

President

HHPHCR12

WELLNESS RIDER

Contrary to any exclusions in the Group Plan, we will pay benefits for one detailed office visit per calendar year for a clinical exam and health counseling, which includes a pap smear and total blood cholesterol screening received by an insured over 2 years of age from a physician.

Detailed Office Visit

Participating Physician	Benefit payable same as shown in the Co-Payment Schedule for Participating Physician Office Visit. Member's initial/annual co-payments and per occurrence co-payments apply, if any.
Non-Participating Physician	Not Covered

Any initial/annual or per occurrence co-payments incurred under this Rider will not apply to the member's Maximum Co-Payment Limit(s).

President

HHPHCR13

WELL CHILD CARE RIDER

Contrary to any exclusions in the Group Plan, we will pay benefits for outpatient preventive well-child care for a covered dependent child to two (2) years of age.

Outpatient preventive well-child care means the charges made by a personal physician for routine pediatric exams and immunizations given to a child as recommended by the American Academy of Pediatrics for children to two (2) years of age. This will be limited to three (3) exams between a child's birth and the first twelve (12) months and two (2) exams between twelve (12) months and the child's second birthday.

Participating Physician	Benefit payable same as shown in the Co-Payment Schedule for Participating Physician Office Visit. Member's initial/annual co-payments and per occurrence co-payments apply, if any.
Non-Participating Physician	Not Covered

Any initial/annual or per occurrence co-payments incurred under this Rider will not apply to the member's Calendar Year Co-Payment Limit(s).

President

AMENDMENT

Humana Health Plan, Inc.
500 West Main Street, Louisville, Kentucky 40202

GROUP PLAN SPONSOR:

HEALTHCARE RECOVERIES, INC.

GROUP PLAN NUMBER: 41308

The Group Plan is amended as set forth in this Amendment, effective as of its renewal date on or after July 15, 1996.

I. **The DEFINITIONS Section on page HP2107.01 is amended by adding the following new language:**

- PROVIDER - means a facility or professional practitioner that is licensed according to law in the jurisdiction in which it, he, or she is located or practices. With respect to a professional practitioner, he or she must be practicing within the scope of license and the services involved must be required to be covered by the laws of the jurisdiction where the treatment is performed. A licensed Ophthalmic Dispenser, Chiropractor, Certified Psychologist, or Psychological Associate is considered a Provider.

II. **The MEDICAL SERVICES Section on page HP7401.03 is amended by adding the underlined new language, as follows:**

7. Obstetrical services received on an inpatient or outpatient basis, including medically necessary prenatal and post-natal care of the mother,

Semi-private accommodations.
Coverage will be provided for:

a. for inpatient care for a mother and her newly-born child for a minimum of forty-eight (48) hours after vaginal delivery and a minimum of ninety-six (96) hours after delivery by Cesarean section; or

b. for a shorter length of stay, with the consent of the mother, if the Physician determines that the mother and the newborn meet medical stability criteria and the Plan authorizes an initial postpartum Home Health Care visit which includes the collection of an adequate sample for hereditary and metabolic newborn screening.

III. **The LIMITATIONS AND EXCLUSIONS Section on page HP7503 is amended to delete reference to the words "and splints" under exclusion 15. The new language will read as follows:**

15. Services and supplies for treatment of temporomandibular joint (TMJ) syndrome/dysfunction and craniomandibular jaw disorder (CMJ) which are recognized as dental procedures. This includes, but is not limited to, the extraction of teeth and the application of orthodontic devices.

IV. The OPTIONAL CONTINUATION OF HEALTH SERVICES COVERAGE Section on pages HP4008.02KY and HP4009, is amended by adding the underlined new language, as follows:

If you are no longer eligible for coverage under the Health Services Agreement of the Group Plan, you may choose to continue these services for up to 18 months after the date your coverage terminates. You must give us written notice of your choice to continue coverage within 31 days after you are given proper notice of your right to continuation.

Continued coverage terminates on the earliest of the following dates: (1) the last day of the 18 month period following the date you were no longer eligible for coverage; (2) the date you became covered for similar group benefits, either on an insured or uninsured basis; (3) the date you fail to make any required subscription fee contribution; (4) the date you reach your Lifetime Maximum Covered Services Amount; or (5) the date the Group Plan terminates and is not replaced by similar group benefits within 31 days.

V. THE ORGAN TRANSPLANT BENEFIT Section on page HP7418 is amended by adding the underlined new language, as follows:

4. Bone marrow (allogeneic, autologous and peripheral blood stem cells) for Wiskott-Aldrich Syndrome, Severe Combined Immunodeficiency Syndrome, Leukemia, Lymphoma, Aplastic Anemia, Ewing's Sarcoma, Neuroblastomas and breast cancer by high-dose chemotherapy (if performed in compliance with the applicable guidelines of the American Society of Blood and Marrow Transplantation and/or the International Society of Hematotherapy and Graft Engineering). We will not cover bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of cancers or diseaseas of the brain, bone, large bowel, ovary, small bowel, testicle, esophagus, kidney, liver, lungs, pharynx, prostate, skin, connective tissue and uterus. We will not cover bone marrow transplants for any congenital, genetic or metabolic disorders affecting or originating in the blood-forming (hematopoietic) system except as stated above as covered.

VI. The TERMINATION FOR CAUSE Section on page HP4002 is amended by adding the underlined new language, as follows:

- **We will terminate a member's coverage for cause under the following circumstances:**

  5. **If a Member or group perpetrates fraud and/or misrepresentation on claims or identification cards in order to obtain services or a higher level of benefits, or the intentional and abusive non-compliance with the provisions of this Group Plan by the member as determined by the Plan. This includes, but is not limited to, the fabrication and/or alteration of a claim or identification card.**

HPSA0213

LOUISVILLE SERVICE AREA

Bullitt County, Kentucky
(Total County - All Zip Codes)

Carroll County, Kentucky
(Total County - All Zip Codes)

Henderson County, Kentucky
(Total County - All Zip Codes)

Henry County, Kentucky
(Total County - All Zip Codes)

Jefferson County, Kentucky
(Total County - All Zip Codes)

Marion County, Kentucky
(Total County - All Zip Codes)

McLean County, Kentucky
(Total County - All Zip Codes)

Meade County, Kentucky
(Partial County - See Zip Code(s) Below)

ZIP Code	Area	ZIP Code	Area
40108	Brandenburg	40155	Muldraugh

Nelson County, Kentucky
(Total County - All Zip Codes)

Oldham County, Kentucky
(Total County - All Zip Codes)

HPSA0214

LOUISVILLE SERVICE AREA (CONTINUED)

Shelby County, Kentucky
(Total County - All Zip Codes)

Spencer County, Kentucky
(Total County - All Zip Codes)

Taylor County, Kentucky
(Total County - All Zip Codes)

Trimble County, Kentucky
(Total County - All Zip Codes)

Union County, Kentucky
(Total County - All Zip Codes)

Washington County, Kentucky
(Total County - All Zip Codes)

Webster County, Kentucky
(Total County - All Zip Codes)

Clark County, Indiana
(Total County - All Zip Codes)

Crawford County, Indiana
(Total County - All Zip Codes)

Floyd County, Indiana
(Total County - All Zip Codes)

HPSA0216

LOUISVILLE SERVICE AREA (CONTINUED)

Harrison County, Indiana
(Total County - All Zip Codes)

Jackson County, Indiana
(Total County - All Zip Codes)

Jefferson County, Indiana
(Total County - All Zip Codes)

Jennings County, Indiana
(Total County - All Zip Codes)

Orange County, Indiana
(Total County - All Zip Codes)

Scott County, Indiana
(Total County - All Zip Codes)

Washington County, Indiana
(Total County - All Zip Codes)

PHYSICIAN AND MEDICAL SERVICES NUMBER

(In Louisville) 580-5050
(Toll-Free) 1-800-448-0222

CLAIMS NUMBER

(Claims status, benefits, I.D. cards, enrollment and eligibility status)

(In Louisville) 580-5100
(Toll-Free) 1-800-992-0678

Kentucky Physicians Plan℠ 620

Humana Health Care Plan

You receive quality coverage at participating hospitals and enhanced coverage by using participating physicians.

Hospital services

Participating hospital services	Plan provides:
■ Inpatient care	80 percent* of reasonable charges after initial annual copaymer
■ Outpatient surgery	80 percent* of reasonable charges after initial annual copaymer
■ Outpatient non-surgical	80 percent* of reasonable charges after initial annual copaymer
■ Hospital emergency room (when not admitted)	80 percent* of reasonable charges after $40 copayment per visi (initial annual copayment does not apply)

Participating hospitals include:

Audubon Regional Medical Center
Southwest Hospital
Suburban Medical Center
University of Louisville Hospital

Physician services

Physician services	Enhanced coverage (participating physician) Plan provides:	Basic coverage (non-participating physician) Plan provides:
■ Office visits for treatment of an injury or illness, including emergency room visits (routine physical exams and outpatient surgery are not covered)	100 percent of reasonable charges after $ 10 copayment per visit	80 percent* of reasonable charges after initial annual copayment
■ Diagnostic testing, x-rays, laboratory tests and allergy testing performed in the physician's office (excluding CAT scans and MRI procedures, which are covered under Other medical services)	100 percent of reasonable charges after satisfying the office visit copayment	80 percent* of reasonable charges after initial annual copayment
■ Allergy injections	100 percent of reasonable charges after $3 copayment per injection	80 percent* of reasonable charges after initial annual copayment
■ Inpatient	80 percent* of reasonable charges (initial annual copayment does not apply)	80 percent* of reasonable charges after initial annual copayment
■ Outpatient (includes surgery performed in the physician's office)	80 percent* of reasonable charges (initial annual copayment does not apply)	80 percent* of reasonable charges after initial annual copayment

*Copayment percentage is applied toward the maximum annual out-of-pocket member expense limit.

Coverage is not provided for non-participating hospital services, except for life- or limb-threatening emergencies or servic not available (prior plan approval required).

Kentucky Physicians Plan gives you a toll-free number for claims and enrollment questions.

Note: Participating hospitals, physicians and providers have agreed to accept our reasonable charge determination as payment in full.

GHC KY-1014

Other medical services

Covered services are subject to:

Initial annual copayment (excludes per visit copayments)	Individual: $ 150 Family: $ 450
Regular copayment	Plan member pays 20 percent up to maximum annual out-of-pocket member expense limit after initial annual copayment
Maximum annual out-of-pocket member expense limit (excludes initial annual copayment and any per visit copayments)	Individual: $ 500 Family: $ 1500

Other medical services include, but are not limited to, covered hospital and physician services not specified elsewhere in the plan as well as the following services:

	Participating provider	Non-participating provider
■ Home health care (up to 60 visits per calendar year)	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Durable medical equipment	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Ambulance	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Skilled Nursing Facility (up to 60 days per calendar year)	80 percent of reasonable charges after initial annual copayment	60 percent of reasonable charges after initial annual copayment
■ Prescription drugs (if drug rider is not included)	80 percent of reasonable charges after initial annual copayment	80 percent of reasonable charges after initial annual copayment

NOTE: Please call the customer service office for information on participating providers: 580-5050

■ Mental and nervous disorders (includes alcoholism and chemical dependency) — Please see separate sheet for coverage details.

Optional coverages
Optional riders are available with this plan.
Please see separate sheets for coverage details.

Maximum lifetime benefit: $1 million

This is a brief plan description. It is not the plan document, and does not include all of the benefits, limitations and exclusions of the plan. Complete terms of the plan are contained in the Group Plan Documents.

GHC KY-1014/1015/1016/1017

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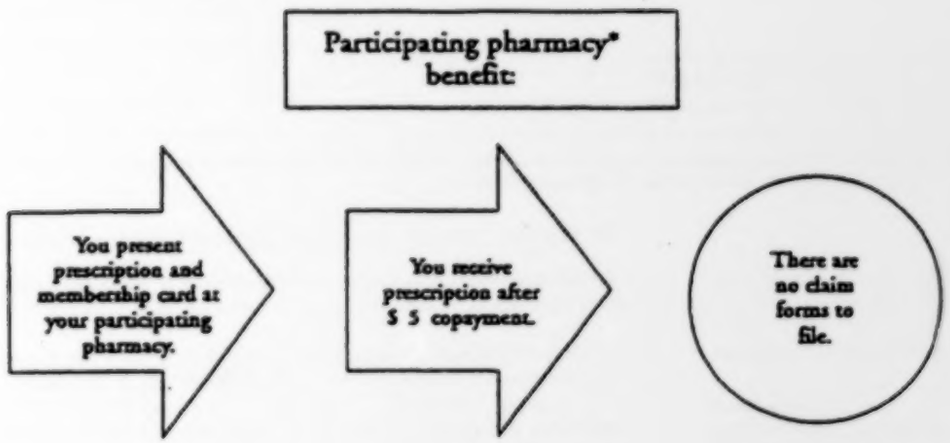
Prescription drug coverage (optional) (PPO)

Humana Health Care Plans

$ 5 copayment per prescription at participating pharmacies.*


Participating pharmacy* benefit:
You present prescription and membership card at your participating pharmacy.
You receive prescription after $ 5 copayment.
There are no claim forms to file.

*Note: For a complete listing of the participating pharmacies in your area, please refer to the participating provider listing.

Prescription coverage is for 100 units or 34-day supply, whichever is less, per prescription or refill.

Please note that generic medication will be used when available. If you prefer a brand name medication when a generic is available, you must pay 100 percent of the additional cost as well as the copayment. If no generic is available, you will receive the brand name medication for only the copayment.

Please refer to the Certificate of Coverage for complete details regarding prescription drug coverage.

GHC KY-0812

In Indiana: Offered and underwritten by Humana Insurance Company
In Kentucky: Offered by Humana Health Plan, Inc.
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PPO
Louisville
S. IN
N. KY
Lexington
1093

Kentucky Physicians Plan℠ for Kentucky and Indiana Accidental injury coverage

Humana Health Care Plans

Accidental injury coverage at 100 percent of the first $200

Coverage includes eligible facility, physician's office and physician charges up to a specified amount.

Initial treatment must begin within 72 hours of the date of the accident.

Includes follow-up treatment, related to the injury, received within 90 days of the date of the accidental injury.

GHC KY-0821

In Indiana: Offered and underwritten by Humana Insurance Company
In Kentucky: Offered by Humana Health Plan, Inc.
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How to handle emergencies when out of the service area using your Kentucky Physicians Plan

What is an emergency?

A true medical emergency is an accident or illness that is of unpredictable onset and which produces severe pain, loss of consciousness, excessive bleeding or poses an immediate threat to life or limb. For exact specifications regarding emergency coverage, please refer to your Certificate of Coverage; however, the following list may be helpful.

Examples of qualified emergency care may include but are not limited to:

- Penetrating wounds such as knife or gunshot wounds
- Choking
- Burns with blisters over large areas of skin
- Displaced limbs
- Head injuries that cause drowsiness, vomiting, confusion, blurred vision or bleeding from the ears, nose or throat
- Sudden or severe chest pain
- Sudden breathing difficulty
- Sudden vision or hearing loss
- Sudden or persistent mouth or nose bleeding or vomiting of blood
- First-time seizures or recurrent frequent seizures that are unresponsive to current medication
- Suspected or confirmed drug overdose (accidental or intentional)
- Suspected or confirmed breathing difficulty or swallowing of poisonous substances
- Unconsciousness
- Blow to the eye resulting in total or partial loss of vision

An illness or injury that requires medical attention but is not life-threatening is generally not considered a medica emergency, for example: flus, colds, sore throats, strains, earaches, headaches, recurrent arthritis, and minor scrape If you use a non-participating hospital under these circumstances, you may not receive coverage. Regardless, you will be responsible for any amount determined to be in excess of reasonable costs.

What to do in an emergency

If you are unable to reach your doctor and a participating hospital is not available, you should obtain treatment a the nearest facility that is equipped to provide emergency care.

You should then contact the Physician and Medical Services Department (502-580-5050 or 1-800-448-0222) within 24 to 48 hours to ensure that proper payment procedures are initiated. If not, you may be subject to all or part of the emergency room charges.

GHC KY-6488

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Preadmission review and prior authorization

Humana Kentucky Physicians Plan

Humana Health Care Plans uses preadmission review to determine medically necessary and appropriate care. Certain medical procedures require that your physician call for pre-approval from the Plan before hospitalization of members. Other services require that physicians submit written prior authorization. Failure to obtain approval may result in reduced or denied coverage, depending on whether the procedure is medically necessary as determined by us.

The following procedures require prior telephone authorization:

- Adenoid removal
- Carpal Tunnel
- Gall bladder removal
- Colon inspection
- Hysterectomy
- Knee arthroscopy (diagnostic and surgical)
- Back disc surgery
- Lumbar spinal fusion
- Magnetic Imaging studies
- Tonsillectomy
- Eardrum surgery

The following procedures require prior written clinical authorization:

- TMD therapies and surgeries
- All durable medical equipment over $500
- Plastic surgery on the eyelids
- Scar revisions
- Breast reconstruction and/or breast reduction
- Removal of breast or breast tissue (excluding biopsy)
- Any cosmetic procedure or procedure that could be considered cosmetic in nature
- Gastric bypass surgery
- Penile implants
- Penile surgery to increase blood flow
- Reconstruction of structures within the throat
- Speech therapy
- Surgery of the jaw
- Internal reconstruction of the nose
- CPAP and/or BIPAP

This list includes only the most common procedures that require prior authorization. Remember, all inpatient hospitalization also requires telephone preadmission. For a complete listing of all procedures subject to prior authorization, or for more information in general, your physician should call **(800) 523-0023**. This number is printed on your Humana Kentucky Physicians Plan membership card.

Humana® Health Care Plans

GHC KY-2373

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Completing a claim form

When completing a claim form

1. Complete the front side of the form. Complete all applicable entries.
2. Use a separate claim for each family member and for each illness or accident..
3. Your group number is the first six digits of the number marked "Gr." on your I.D. card.
4. Always sign the box marked RELEASE OF INFORMATION/SUBROGATION ACKNOWLEDGMENT.
5. If you wish for payment to go directly to your physician or other provider, you can assign payment by signing the box marked IF PAYMENT IS TO BE SENT DIRECTLY TO PROVIDER.
   If you have already paid the physician or other provider, do not sign the box.

Checking on the status of a claim

1. Call the toll-free claims number shown on your Humana Health Care Plans identification card. All telephone conversations are recorded and the claims representatives will identify themselves by name. Make a note of the time, date and the name of the claims representative for future reference.
2. Have the following information ready:
   - Name of the person who received services
   - Date of service
   - Subscriber's social security number
   - Dollar amount of the claim, if possible.
3. Here are some common causes for delays in settling claims:
   - Incorrect addresses
   - Incorrect subscriber identification numbers
   - Insufficient accident information
   - Coordination of benefits with other insurers
   - Incomplete diagnosis by the physician
   - Non-compliance with preadmission review and prior authorization requirements
   - Bills not itemized
   - Drug names omitted.

Keeping complete records

Remember to keep copies of all bills you receive for medical services, including prescripion drugs.

Note: **When you receive services from a participating hospital, you do not need to file a claim for those services. However, you may receive bills from other providers who are not hospital employees, such as physicians, anesthesiologists, radiologists and pathologists. If you receive separate bills from these providers, you will need to file claims for their services.**

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Provisions of Kentucky Physicians Plan

Humana Health Care Plans

The following provisions are common to each plan:

Coordination of services
Physicians plan services are coordinated with similar services under other group hospital and medical plans. If we are the secondary carrier, our benefit will be the difference between the primary carrier's payment and 100 percent of eligible charges. In no event will use of the coordination of services provision cause the company to pay more than it would have paid, if no other coverage was involved. Your Group Plan/Certificate of Coverage will explain coordination of services in more detail.

Initial copayment credit for takeover groups
Any initial annual copayment amounts accumulated by a member under the employer's current group insurance contract will be credited toward the initial annual copayment amount, such person (employee and/or their eligible dependents) must pay for "Medical services" under the Group Plan.

Dependent coverage
Eligible dependents include the employee's spouse and unmarried children from date of birth to their 19th birthday or to their 25th birthday for full-time students.

Eligibility
Kentucky Physicians Plan is available to members of groups where a formal employer-employee relationship exists.

Pre-authorization requirement
You (plan member) must receive pre-authorization to determine that each surgery, hospital admission and medical procedure/service meets our guidelines of reimbursable, medically necessary treatment. To obtain pre-authorization, you must present your identification card, which shows our toll-free pre-authorization telephone number to the physician. Your physician must call for pre-authorization. If pre-authorization is not obtained, benefits may be reduced by 50 percent for medically necessary services that were provided without authorization. You may be required to pay the entire cost of services you receive if authorization is denied, or if we later determine that the services weren't medically necessary or eligible for coverage.

Skilled nursing facility
The Group Plan provides coverage in a skilled nursing facility each calendar year (requires prior approval by us). Coverage for room and board is based on the facility's most common semi-private rate.

Home health care
The Group Plan provides home health care on a calendar year basis (requires prior approval by us). Coverage is limited to our schedule of reasonable charges.

Maternity services
The Group Plan will provide maternity services for employees and their spouses on the same basis as coverage payable for any other illness. Check your Group Plan/Certificate of Coverage to determine if dependents are eligible for maternity coverage.

Pre-admission testing
Under the Group Plan, pre-admission testing is fully covered at 100 percent. The initial annual copayment amount does not apply.

Pre-existing conditions for new employees entering the Group Plan.
Under the Group Plan, a pre-existing condition is a sickness or injury for which the covered member received treatment (including prescription drugs), consultation or advice during the three-month period immediately prior to the effective date of his or her coverage.

A pre-existing condition will not be covered until the date the covered member completes 12 consecutive months of membership in the Group Plan or the member is free of treatment for a three consecutive month period.

Second surgical opinion
The Group Plan provides full coverage for all second surgical opinions (including additional, not previously completed x-rays and laboratory tests). Second surgical opinions are not subject to any copayments.

Physicians service coverage for non-participating hospitals
If your participating physician admits you (insured) to a non-participating hospital, your coverage for physician services may be reduced, except for a true medical emergency, or if a service is not available at a participating hospital.

Waiting period for membership
At the employer's option, new employees may be subject to a waiting period for the membership in the Group Plan.

The provisions shown here are subject to change without notice.

Limitations and exclusions

Unless specifically stated otherwise, no coverage will be provided for, or on account of the following items:

1. A sickness or injury which is covered under any workers' compensation or similar law.
2. Any service the member would not be legally required to pay for in the absence of this coverage.
3. Sickness or injury for which the member is in any way paid or entitled to payment or care and treatment by or through a government program, other than Medicaid.
4. Education or training; medical services provided by the member's parent, spouse, brother, sister or child.
5. Experimental drugs or substances not approved by the Food and Drug Administration; drugs or substances used for other than Food and Drug Administration approved indications; or drugs labeled: "Caution – limited by federal law to investigational use."
6. Vitamins, birth control pills, unless medically necessary for a medical condition, and non-prescription drugs or medicines.
7. Treatment, services, supplies or surgery that are not medically necessary.
8. Purchase or fitting of hearing aids or advice on their care.
9. Weekend non-emergency hospital admissions.
10. In-vitro fertilization; any medical or surgical treatment of infertility; infertility evaluations; sex change services; or reversal of elective sterilization.
11. Procedures or treatment methods determined by us to be experimental.
12. Cosmetic and reconstructive surgery, unless medically necessary as specified in the Group Plan/ Certificate of Coverage.
13. Any service or supply for dental services, treatment of teeth or periodontium, oral surgery, or any other orthodontic treatment regardless of medical necessity, except as specified in the Group Plan/ Certificate of Coverage.
14. Any service, supply or treatment connected with custodial care.
15. Sickness or injury caused by the member's:
    (a) engaging in an illegal occupation; or
    (b) commission of or an attempt to commit a criminal act.
16. Any surgical procedure to reduce obesity, unless medically necessary.
17. Elective abortion, unless the physician certifies in writing that the pregnancy would endanger the life of the mother.
18. Pregnancy of a child, except for:
    (a) complications arising from it, or
    (b) pregnancies resulting from rape or incest.
19. Vision analysis, testing or orthoptic training or the purchase of eyeglasses or contact lenses.

This is just a partial list of limitations and exclusions and is subject to change without notice. Please check the Group Plan/Certificate of Coverage for a complete listing.

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